Avoiding Mistakes in Dermatology

Richard P. Usatine, MD, FAAFP
Professor of Dermatology and Cutaneous Surgery
Professor of Family Medicine
University of Texas Health San Antonio
Founding Director, University Health System Skin Clinic
San Antonio, TX

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Disclosure

I have no financial interests or relationships to disclose.

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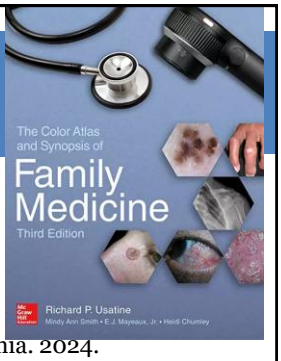
Additional Disclosure



- Visual Dx, Contributing photographer, Family Medicine Editor
- Author, 12 medical books including:
  - Dermatologic Procedures in Office Practice. 2nd edition. Elsevier, Inc., Philadelphia. 2024.
  - The Color Atlas and Synopsis of Family Medicine. 3nd Edition. McGraw-Hill, New York, 2019
  - The Color Atlas of Internal Medicine, McGraw-Hill, New York, 2015
  - The Color Atlas of Pediatrics, McGraw-Hill, New York, 2014
  - Cutaneous Cryosurgery. 4th Edition. Taylor and Francis, London, 2014
- Co-President, Usatine Media
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Learning Objectives

1. Identify the common mistakes made in dermatology
2. Develop strategies to avoid these mistakes
3. Improve the diagnosis and treatment of common dermatology conditions.

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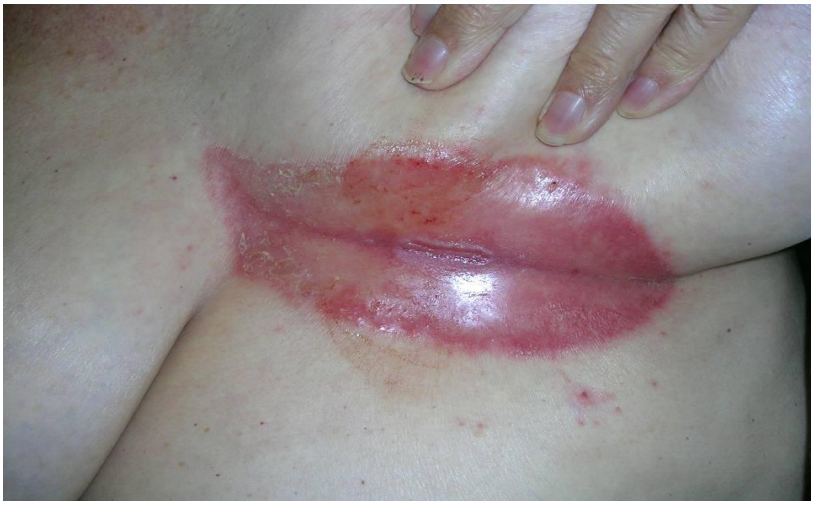
What Is the Most Likely Diagnosis?

A. Tinea
B. Candida
C. Erythrasma
D. Psoriasis



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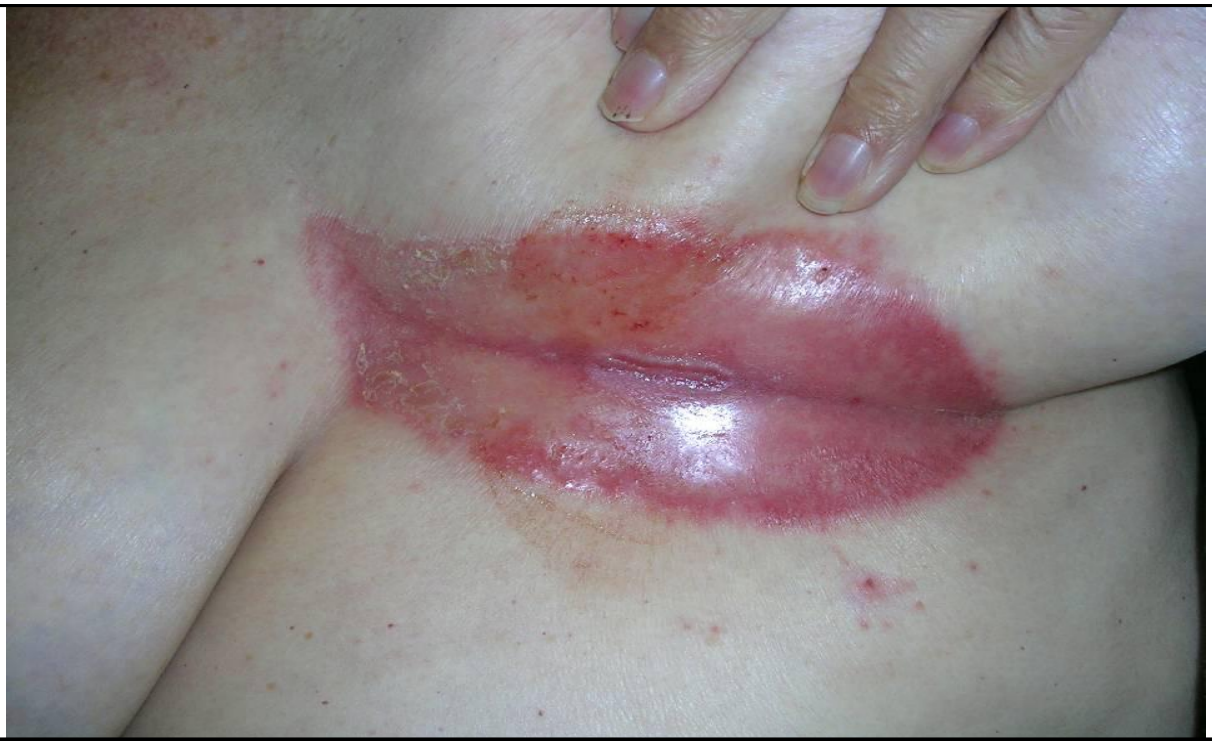

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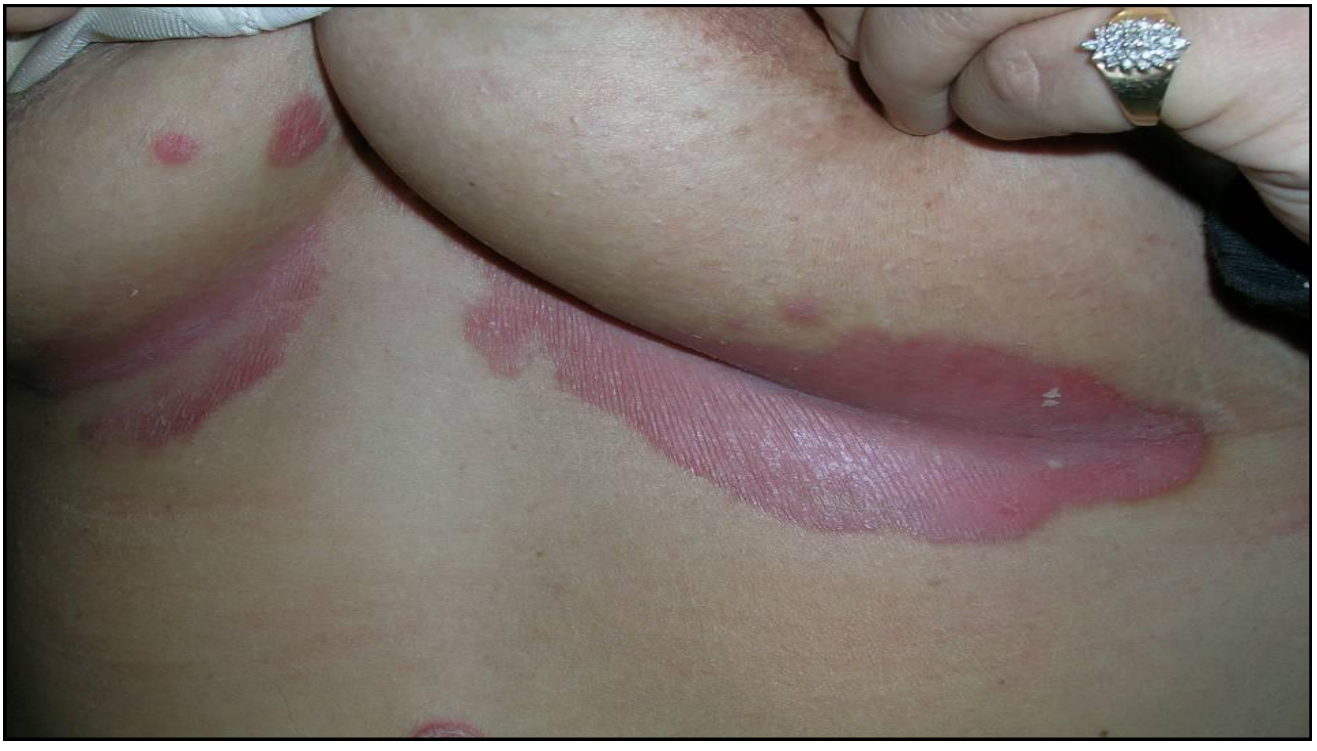

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What Is the Most Likely Diagnosis?

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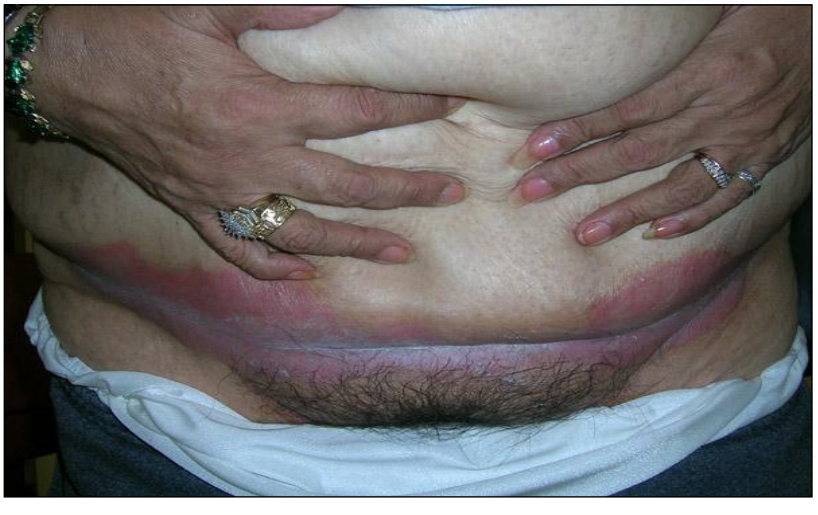

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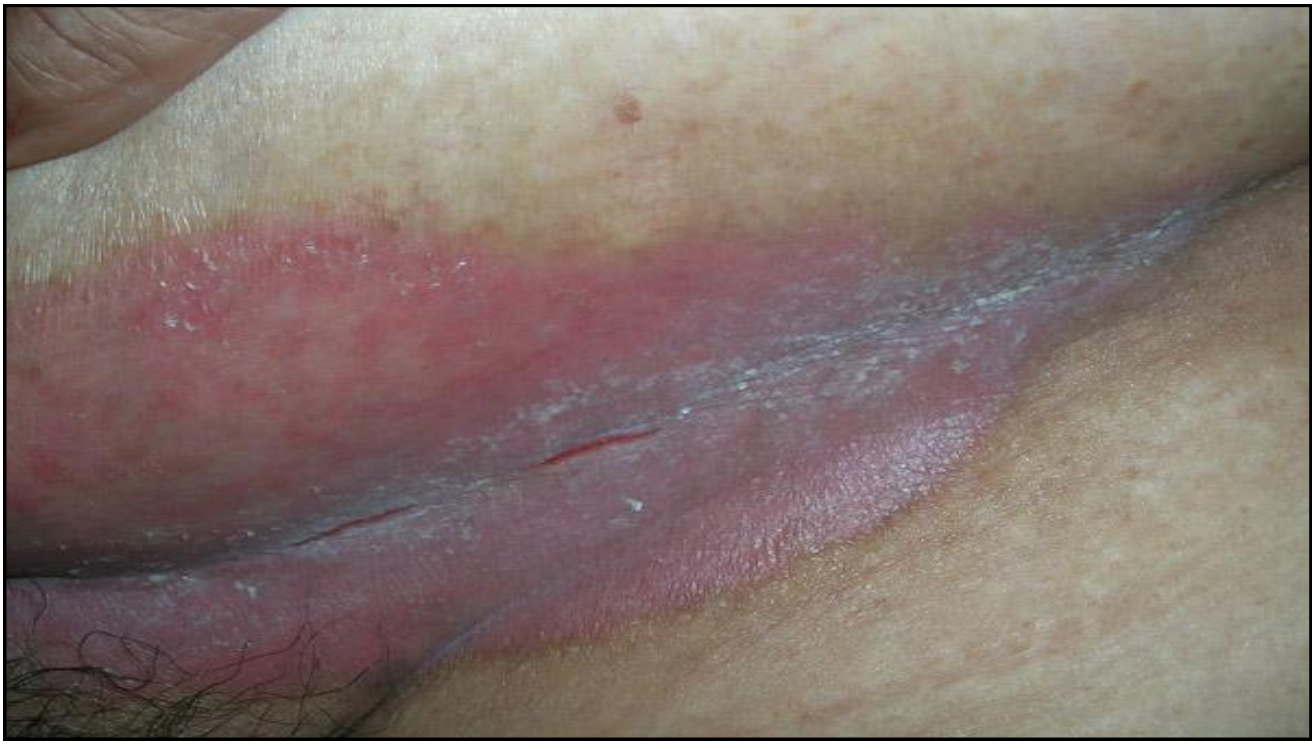

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Inverse Psoriasis

- Found in the intertriginous areas of the axilla, groin, inframammary folds, and intergluteal fold. It can also be seen below the pannus or within adipose folds in overweight individuals.
- The name inverse refers to the fact that the distribution is not on extensor surfaces but in areas of body folds.

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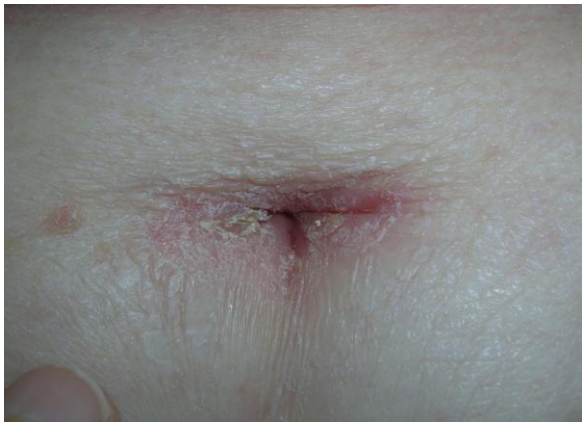
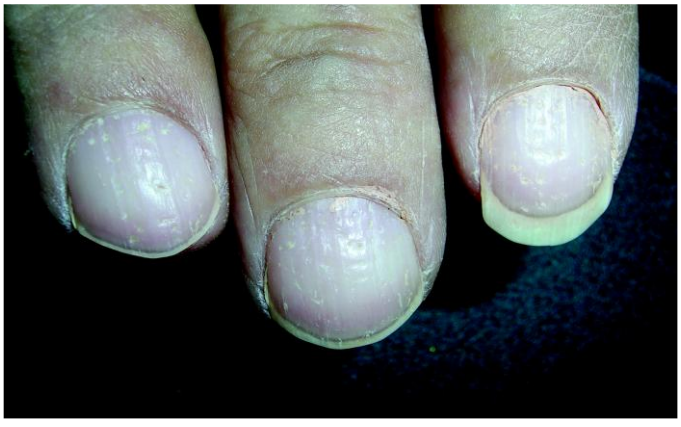
Look for Clues At Other Sites





Sites above pt may not notice but still look at knees and elbows too.

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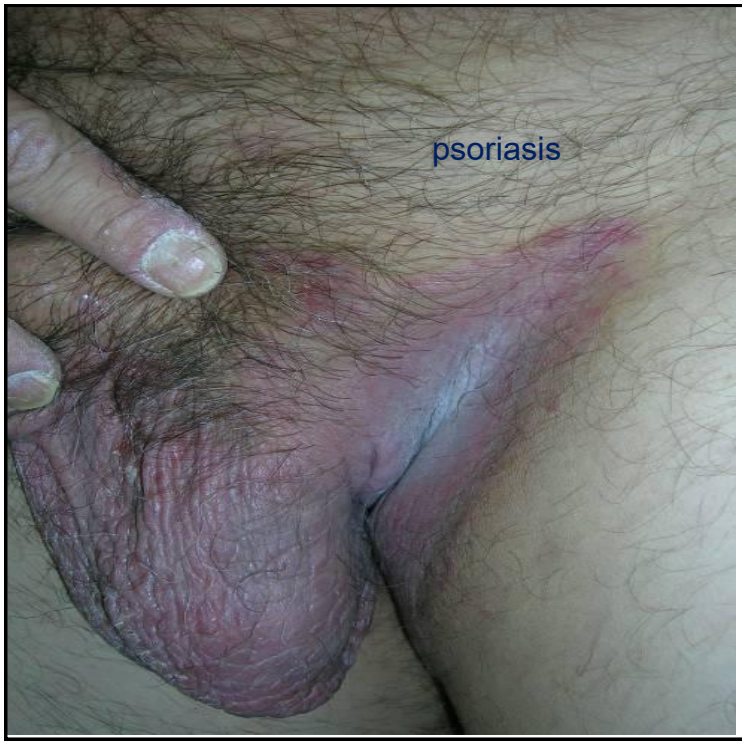
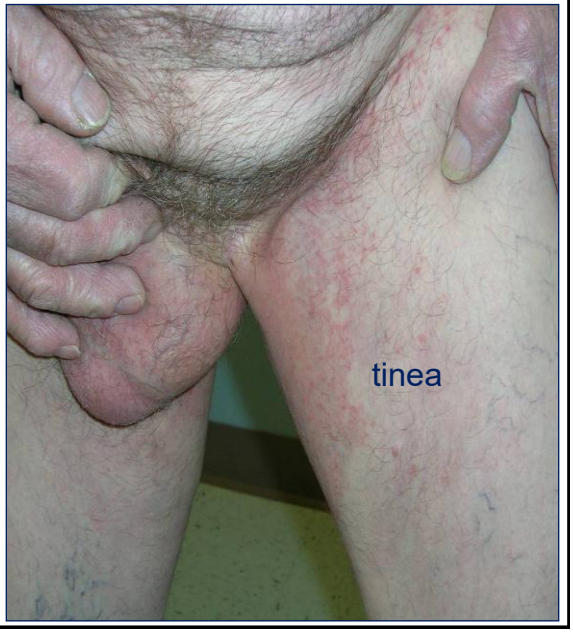


Psoriasis or Tinea?



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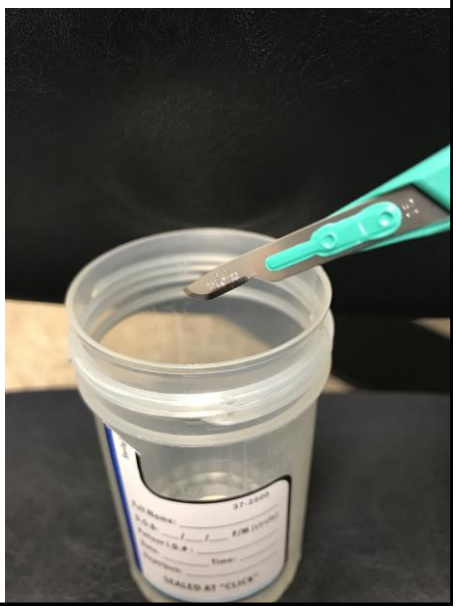
Making the Diagnosis of Intertriginous Rashes

- Look for clues in nails and other sites
- Did patient already fail antifungal medications?
- KOH preparation/fungal culture first if suspect fungal infection is possible
- Wood's lamp if considering erythrasma (coral red fluorescence)
- Punch biopsy if treatment not working and still stumped



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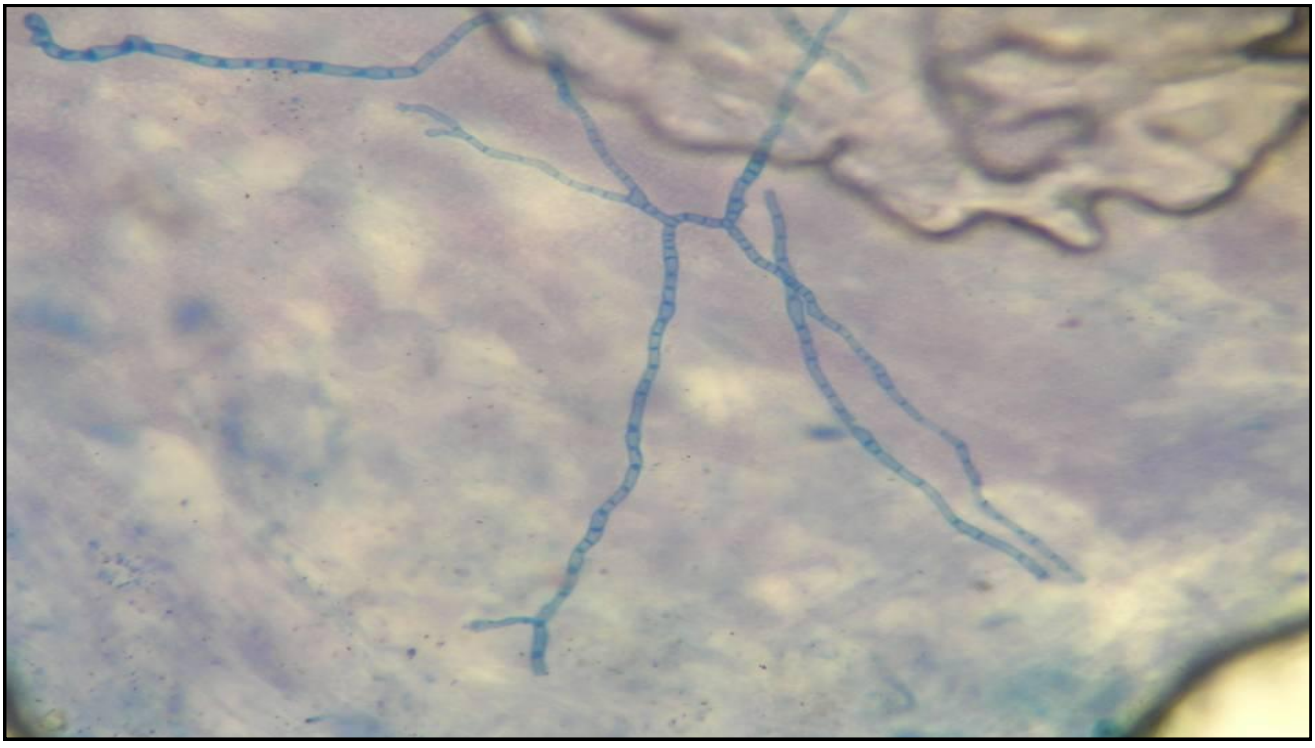

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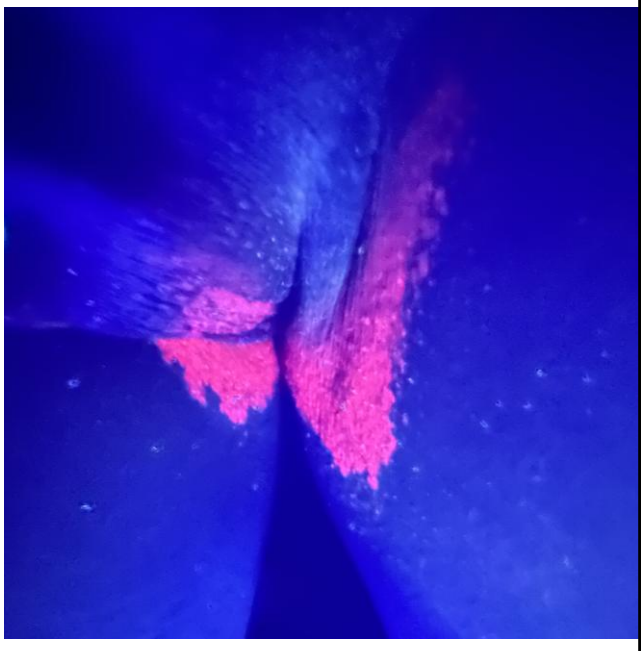
Erythrasma

Coral red fluorescence with UV - Wood's lamp

Bacterial!



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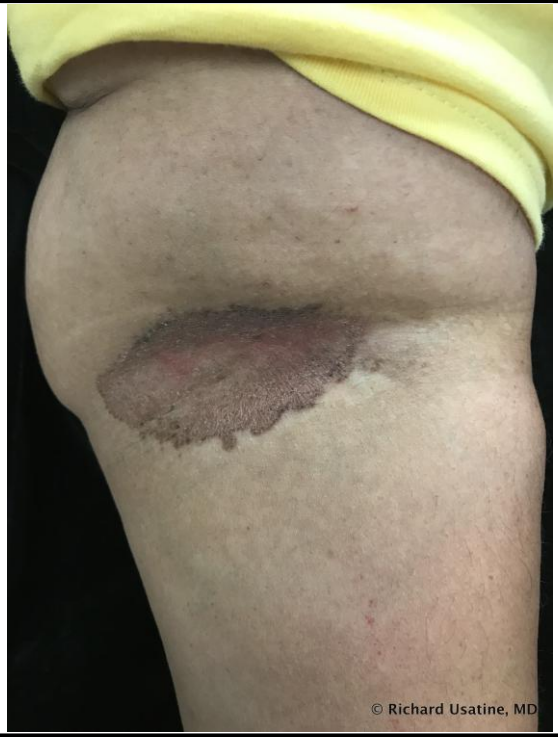
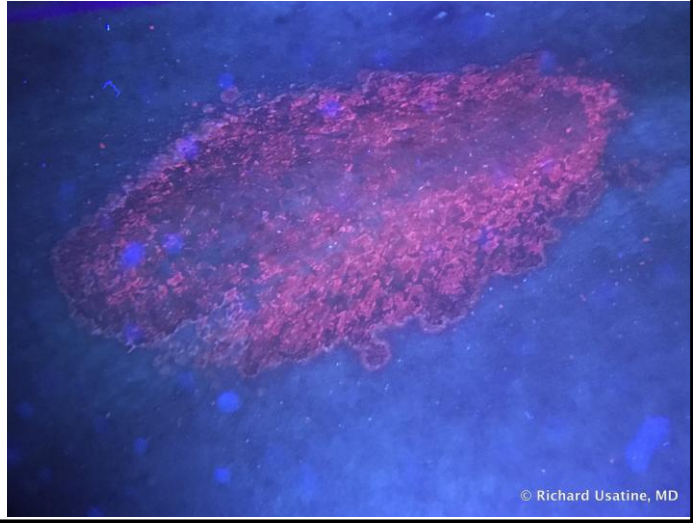


Erythrasma - Coral Red with UV Light



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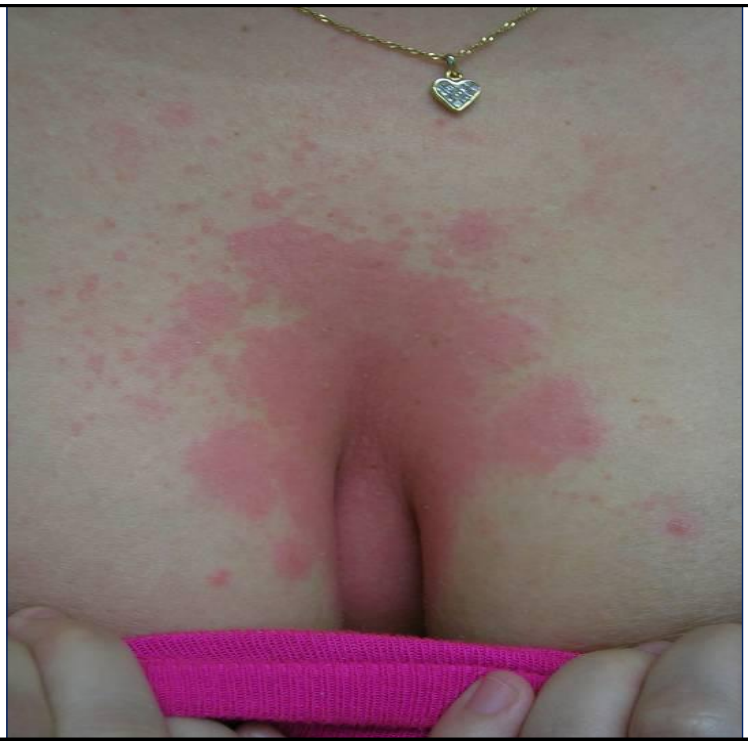

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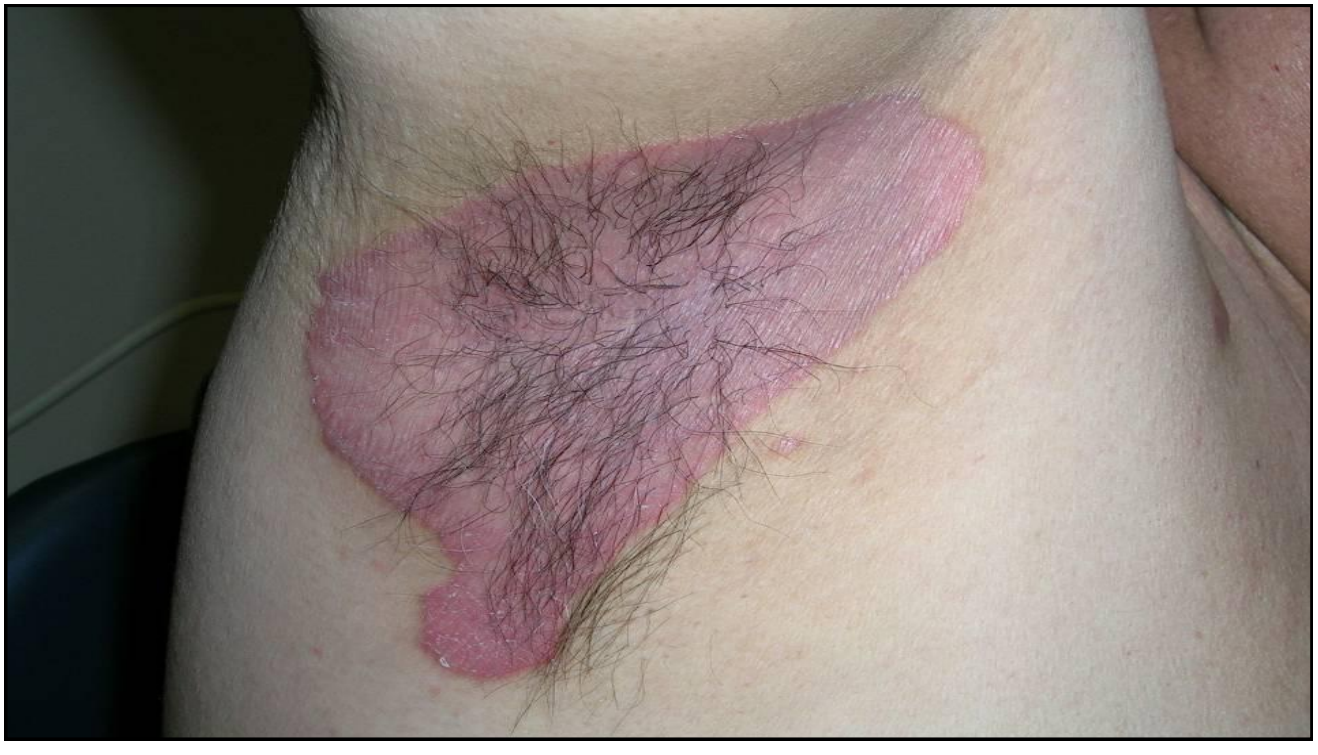

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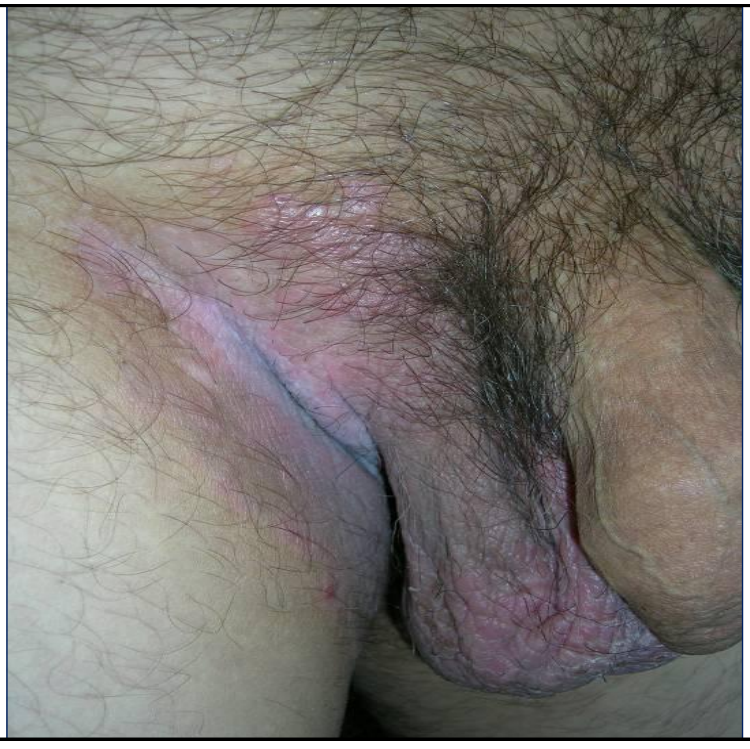

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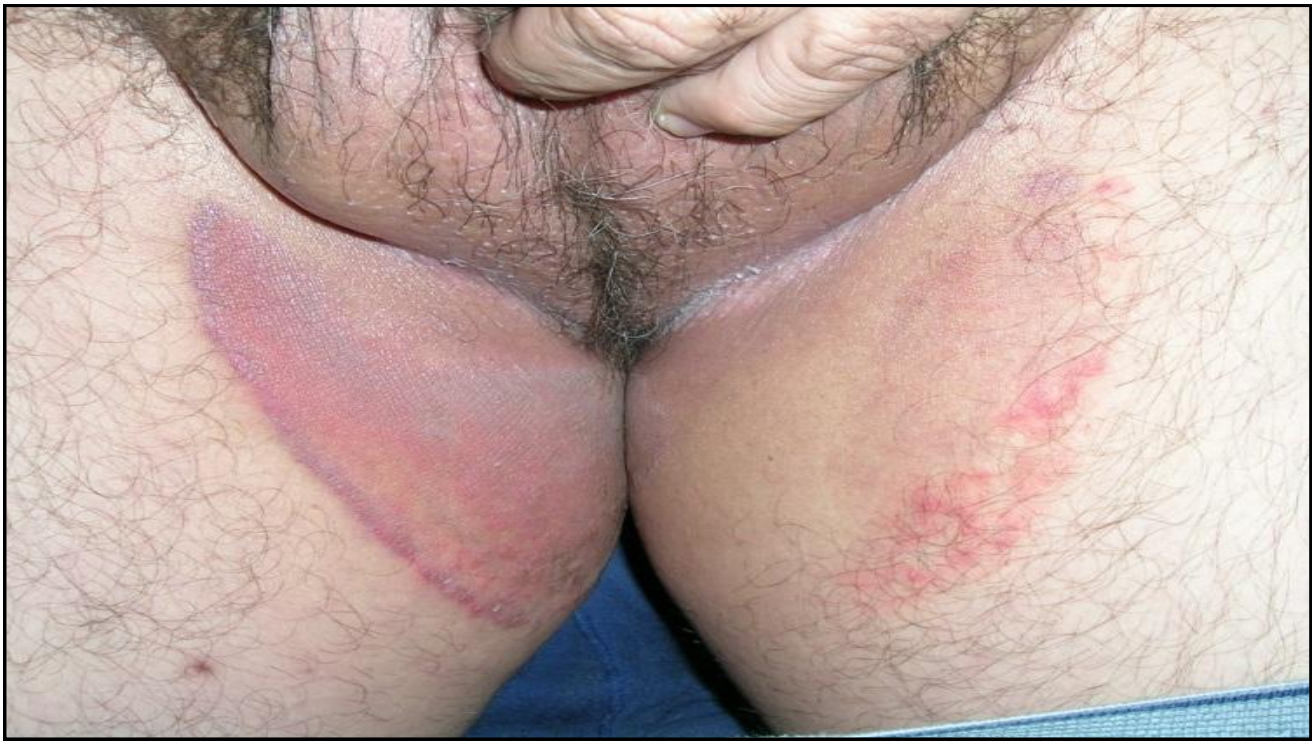

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Treatment Options for Inverse Psoriasis

- 0.1% triamcinolone cream (or ointment)
- Reserve higher potency steroids for failures of triamcinolone (fluocinonide, clobetasol, …)
- Steroid sparing and more expensive:
  - Tacrolimus ointment
  - Calcitriol ointment
  - Calcipotriene cream

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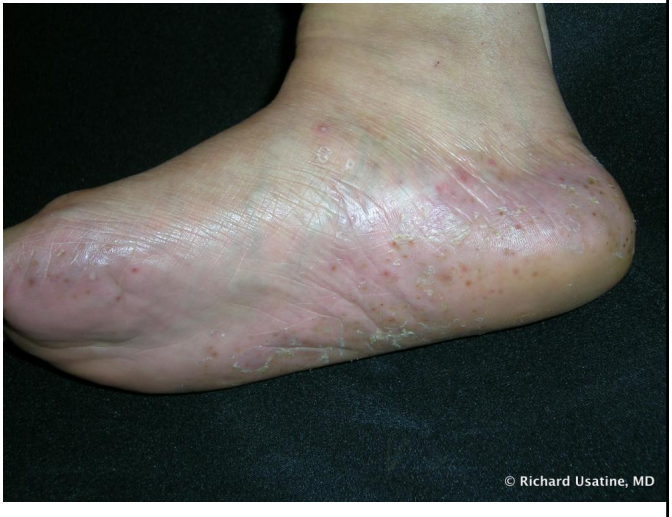
What Is the Most Likely Diagnosis?

A. Tinea pedis
B. Contact dermatitis
C. Dyshidrotic eczema
D. Psoriasis



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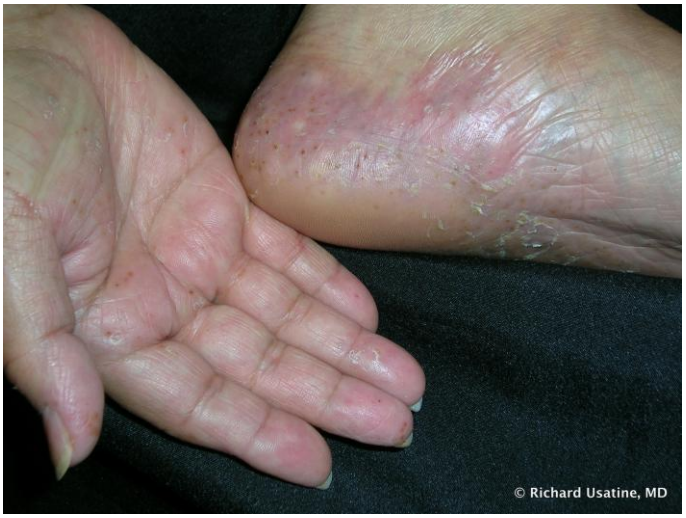
Palmar Plantar Psoriasis

- psoriasis that occurs on the plantar aspects of the hands and feet (palms and soles).



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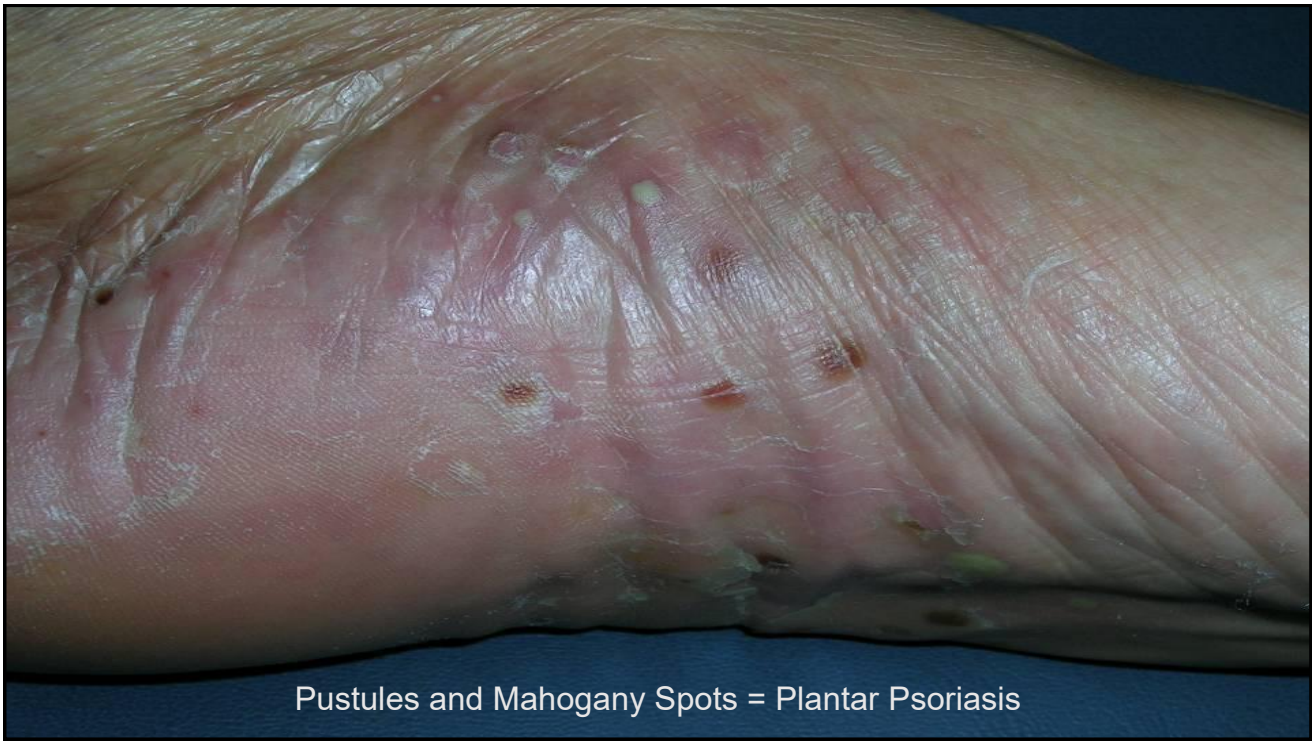

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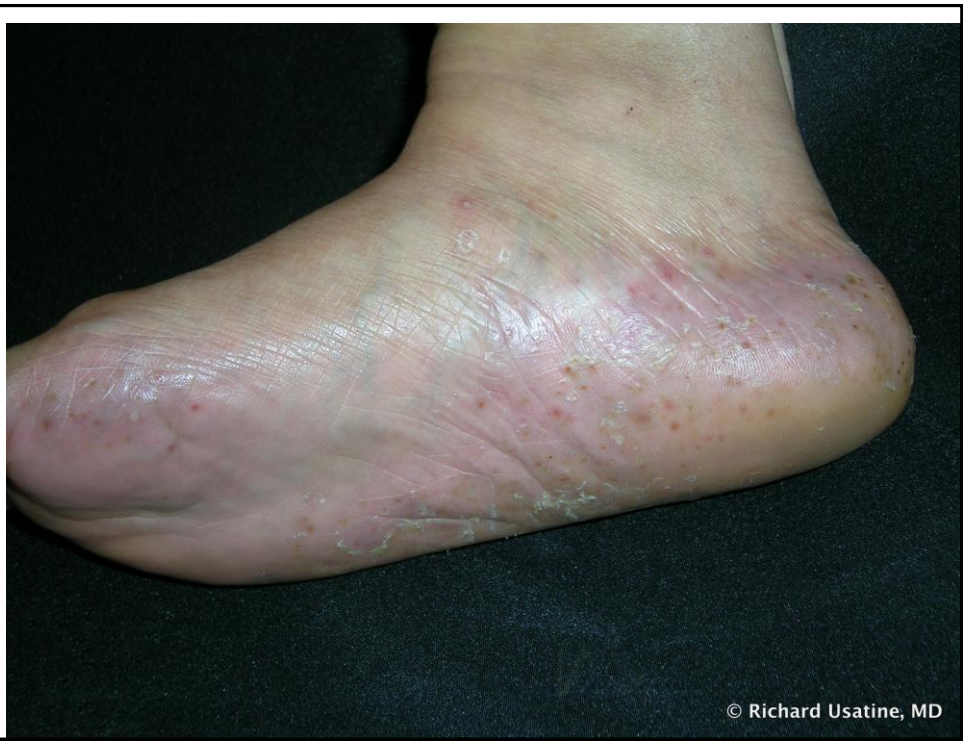
See the Pustule and Mahogany Spots Now?



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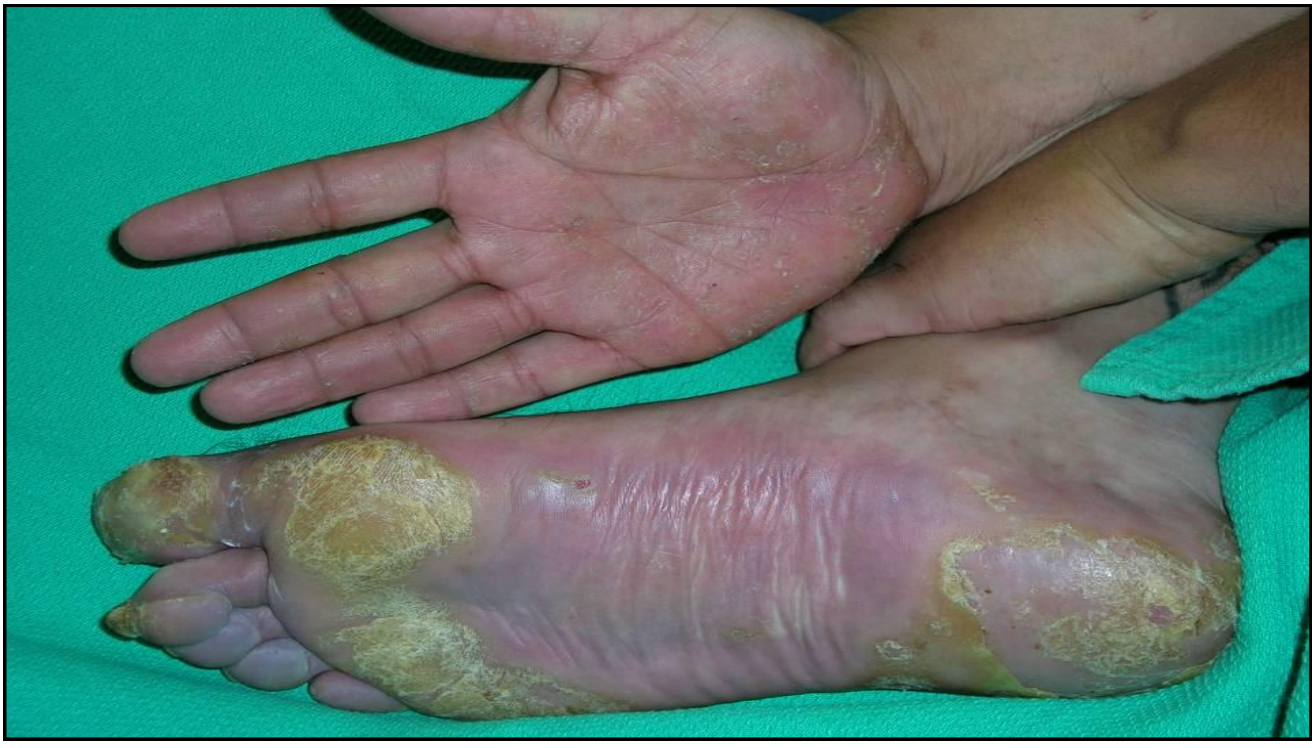

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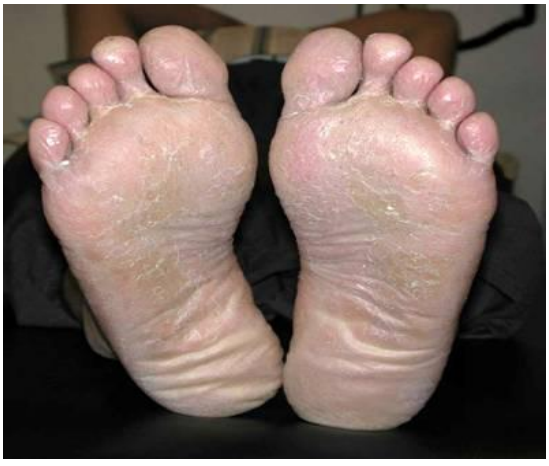
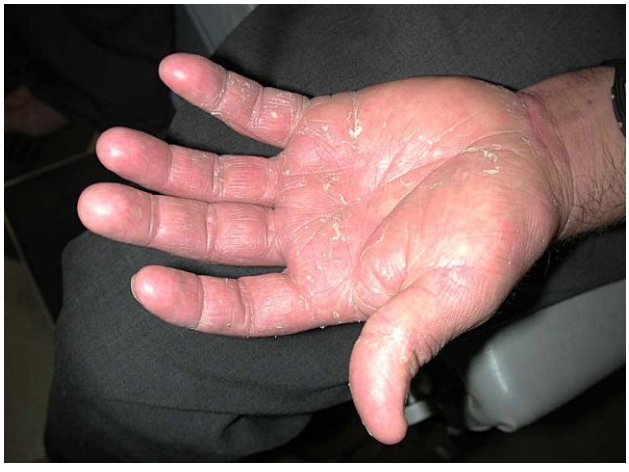
Two Feet One Hand Syndrome





Tinea!

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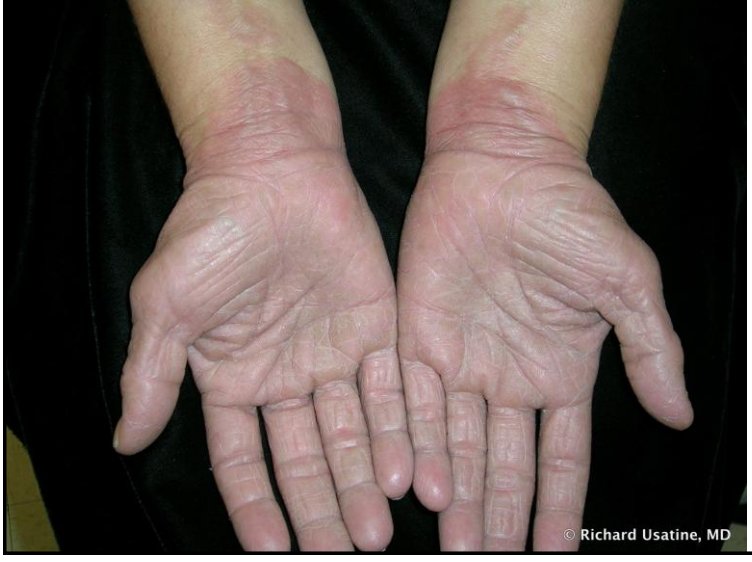
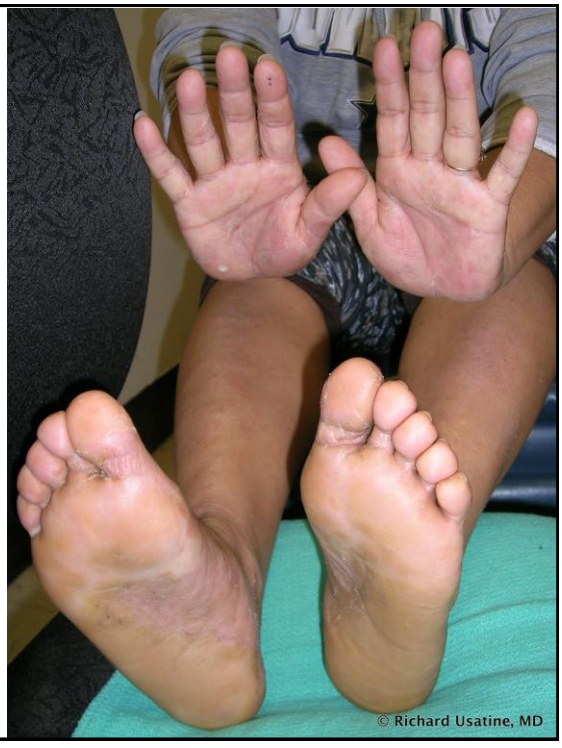
Both Hands and Feet

Psoriasis





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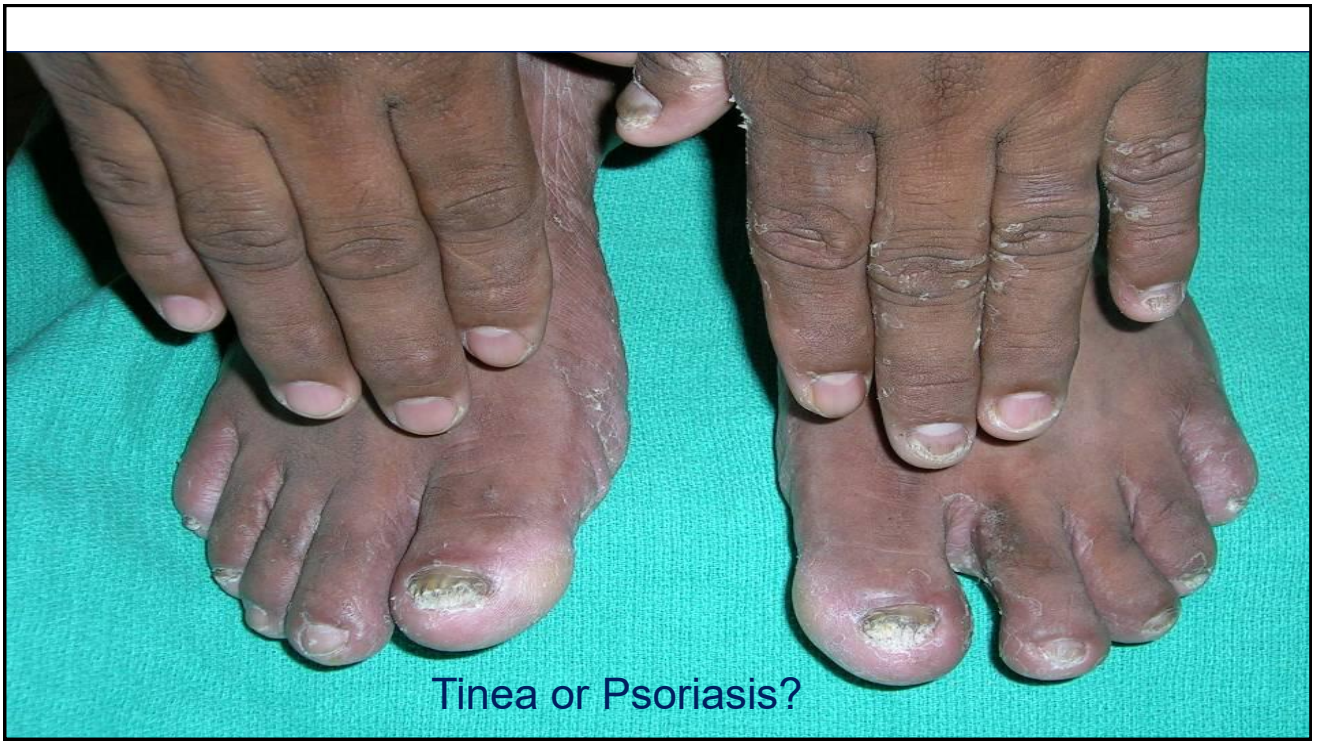

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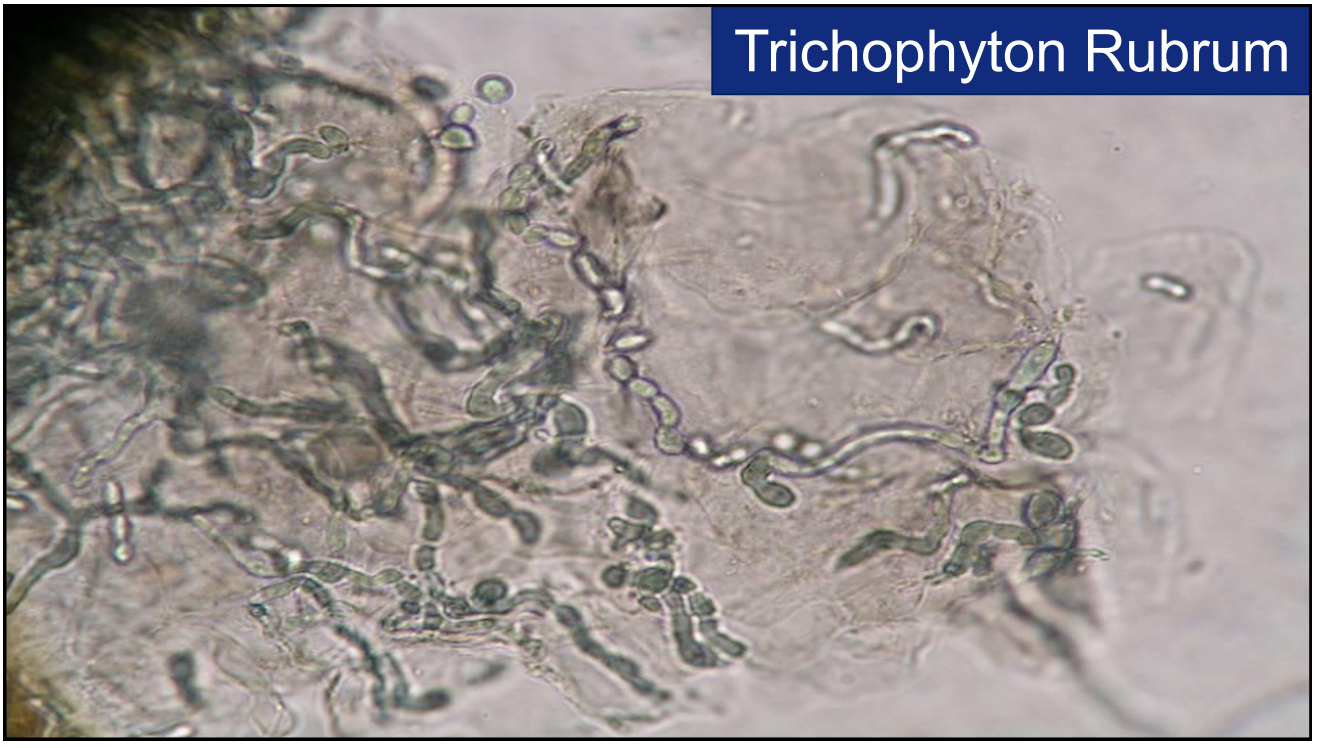

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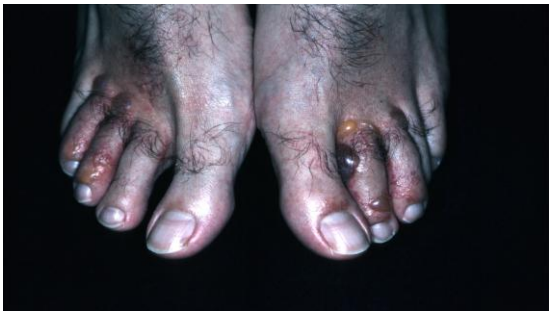
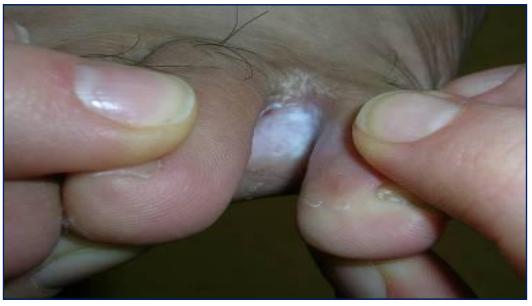
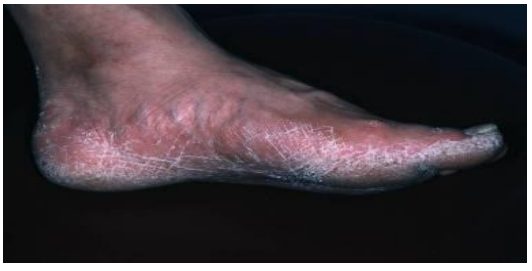
Tinea Pedis

- interdigital
- moccasin distribution
- vesicular







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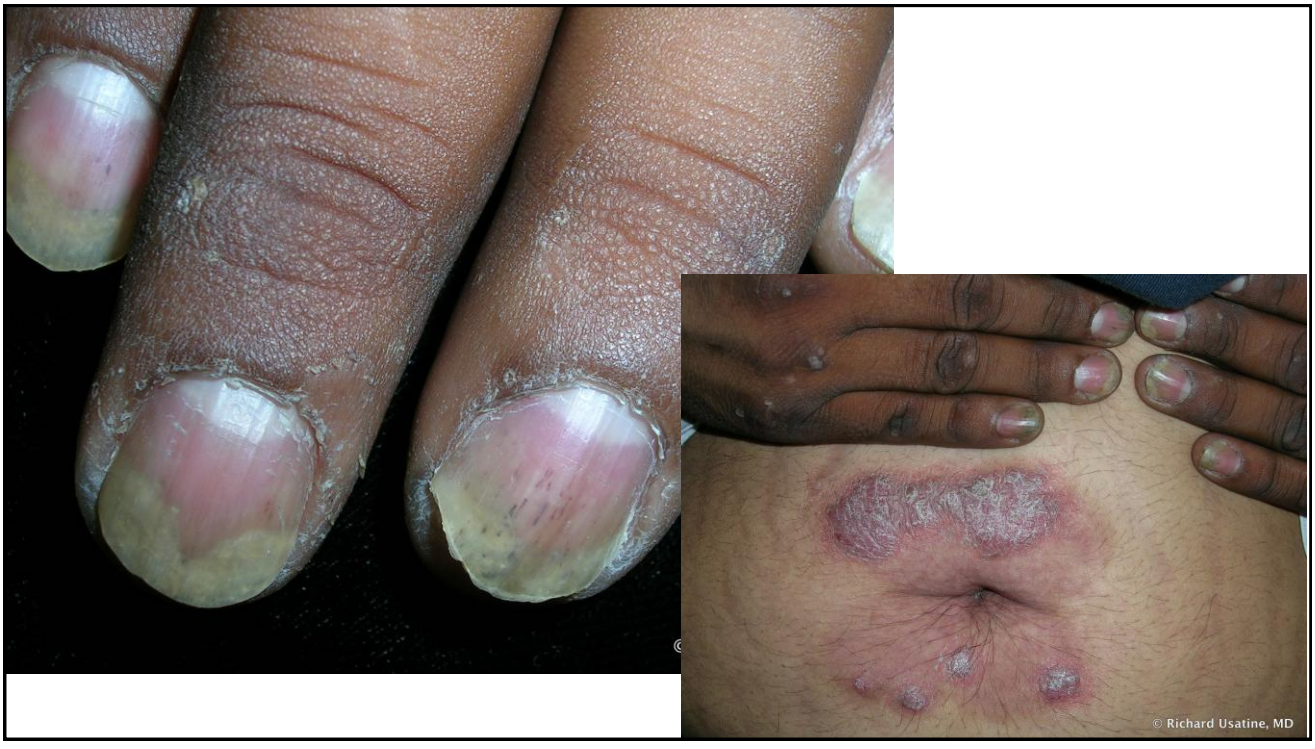
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Nail Psoriasis Can Look Fungal

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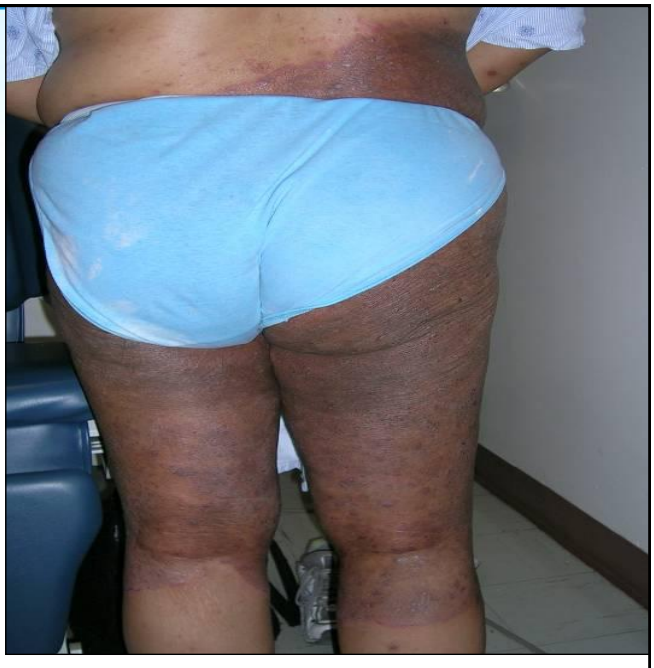
What Is the Most Likely Diagnosis?

A. Psoriasis
B. Contact dermatitis
C. Tinea corporis
D. Severe eczema



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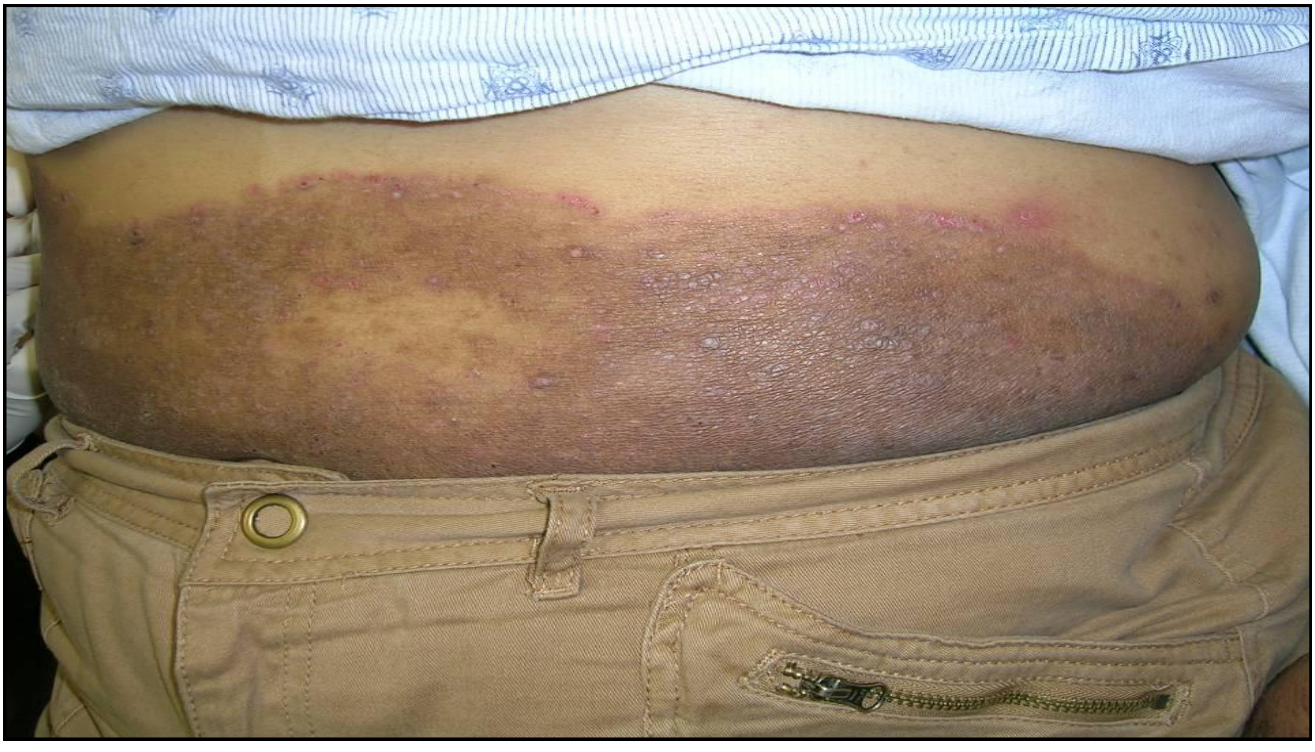

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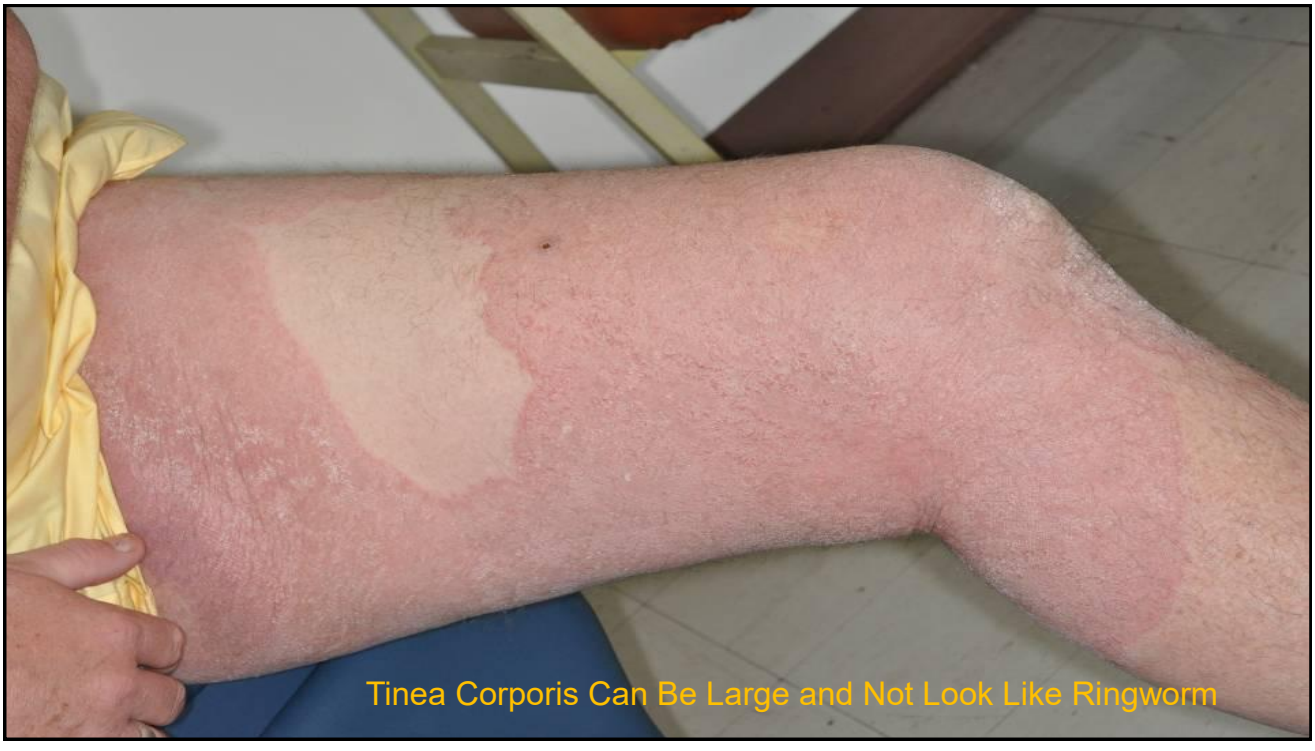
Tinea Corporis Can Be Large and Not Look Like Ringworm

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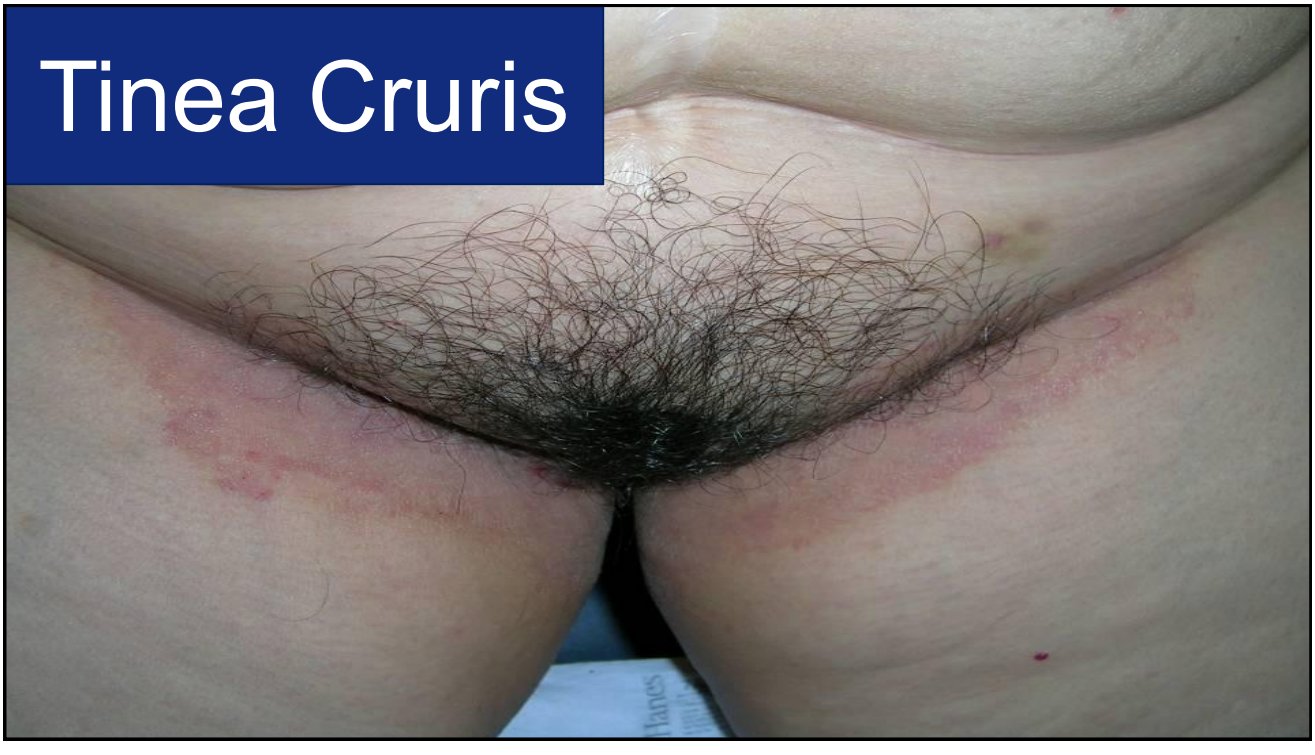
Tinea Cruris

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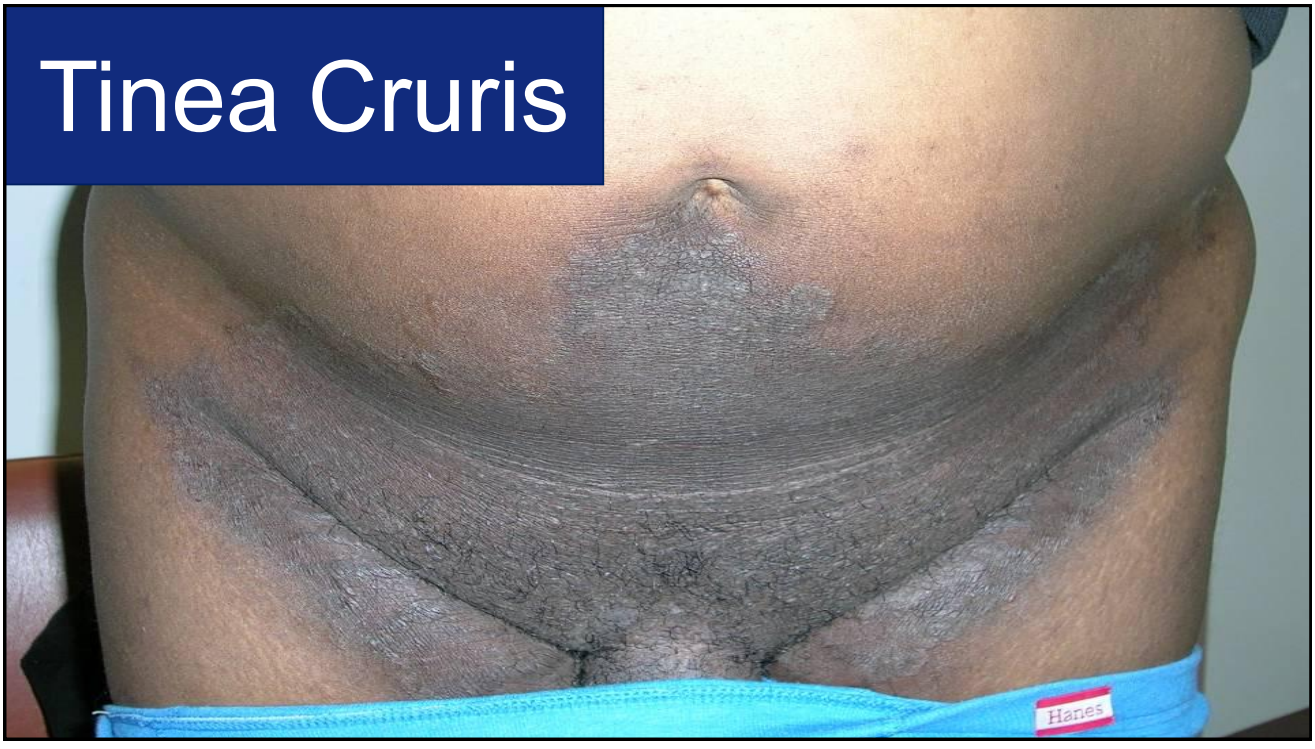
Tinea Cruris



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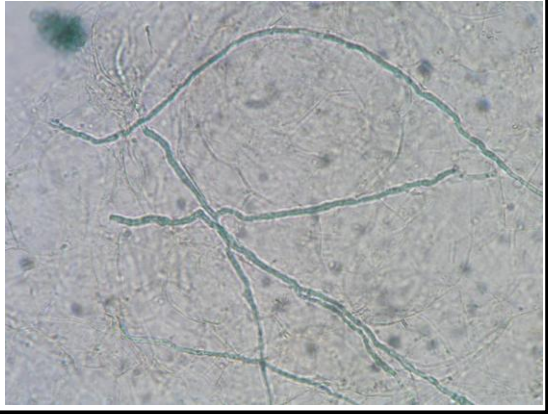
Tinea Cruris/Corporis

- KOH/culture is best method for diagnosis

- look at feet for source of infection
- treat with topical antifungal
- not nystatin!!



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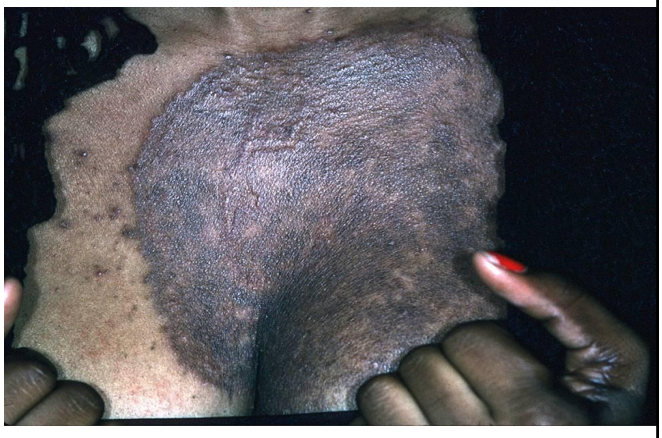
B. Contact dermatitis
C. Tinea
D. Severe eczema



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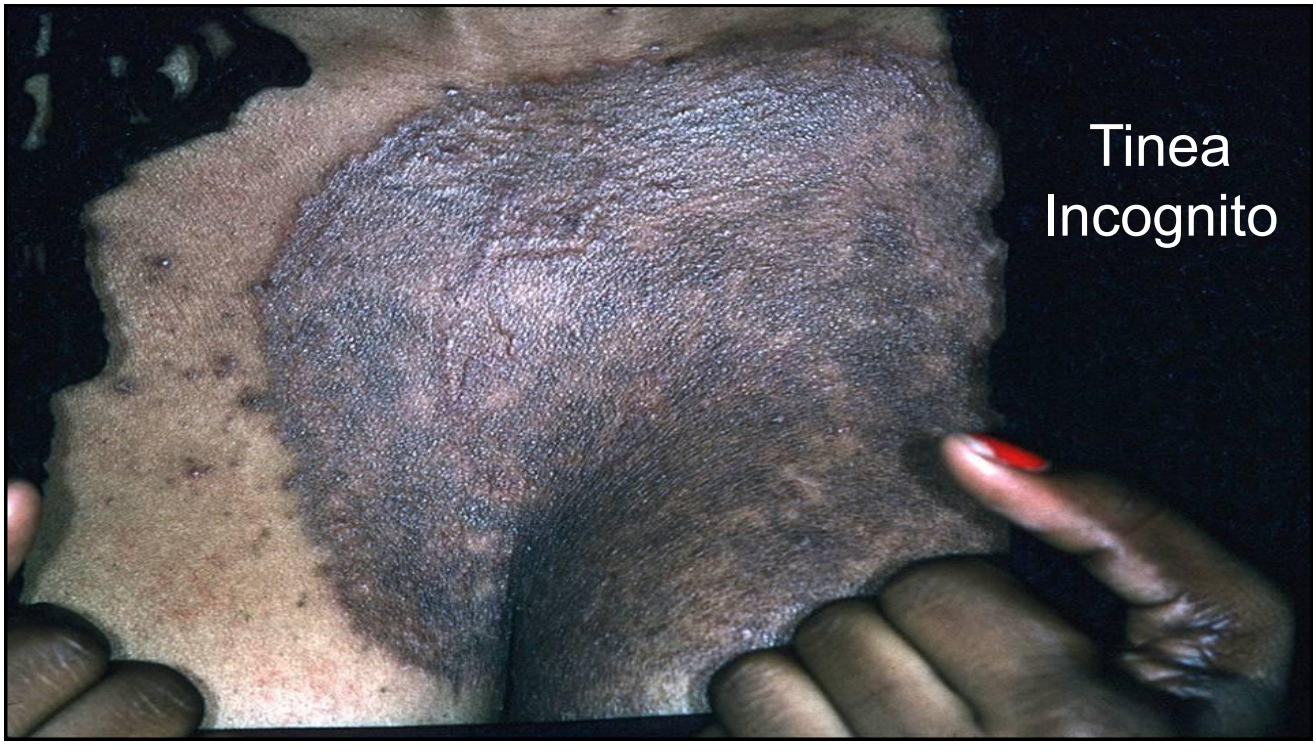

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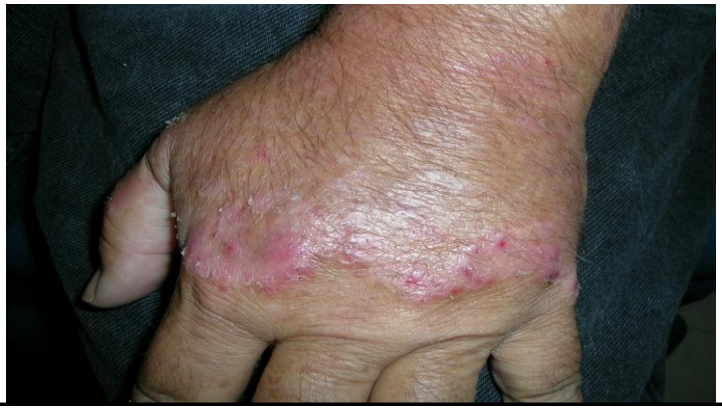
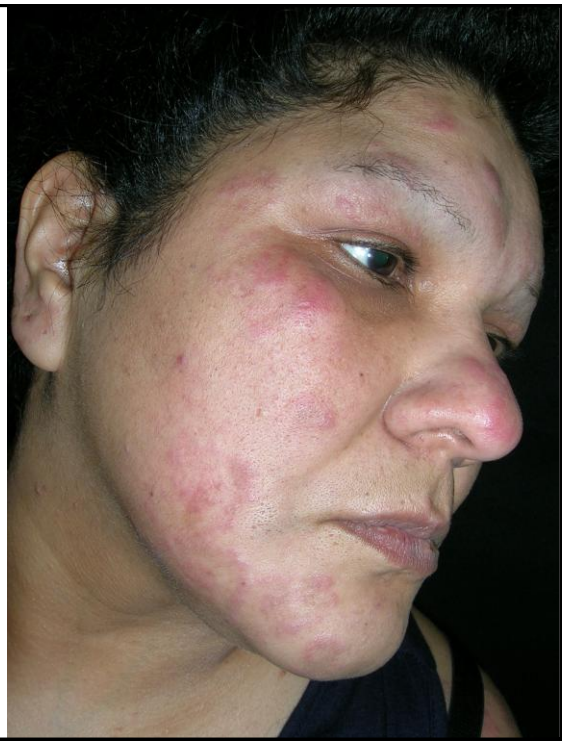
Fungus on Steroids

- Treating an unknown case of tinea with steroids creates:
  - Tinea incognito





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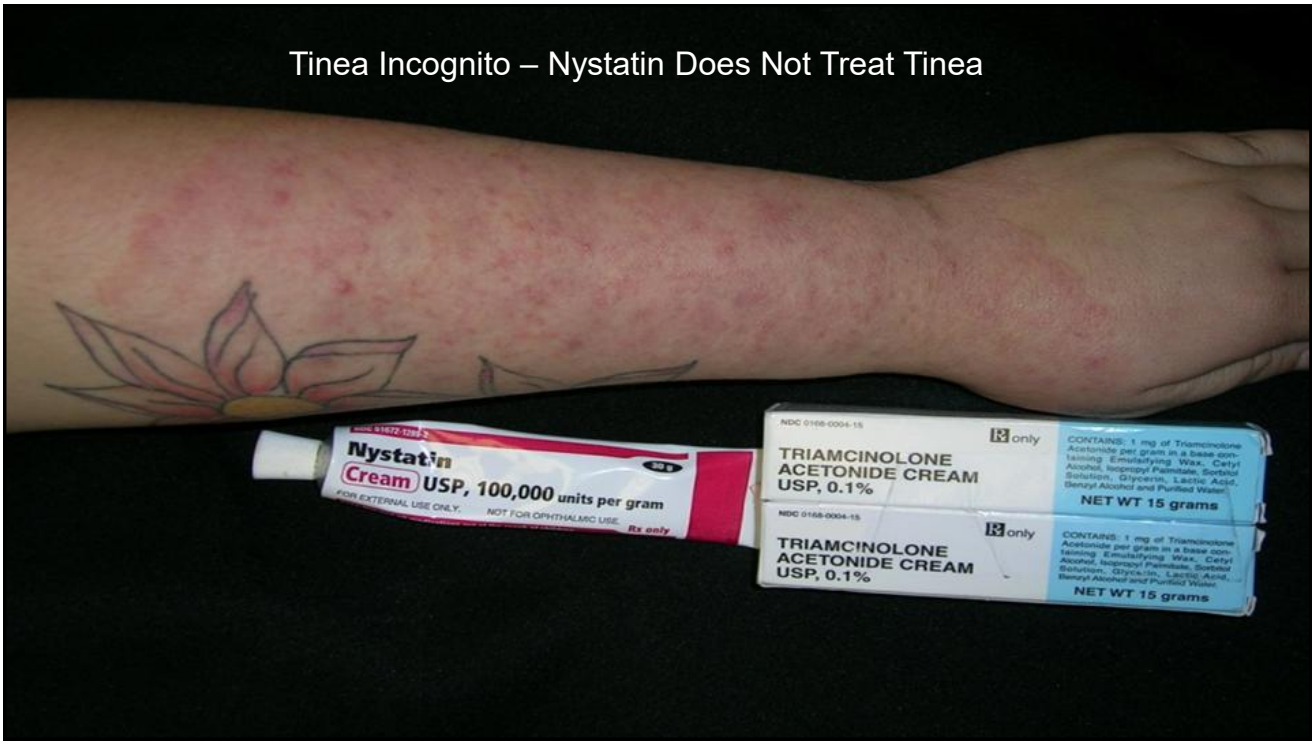

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What Does Treat Tinea?

- Topical terbinafine, clotrimazole, or miconazole, butenafine OTC
  - Various prescription azoles
- No benefit to combination product with steroid
- Oral terbinafine 250 mg daily when large areas are involved or there is deeper infection after topical steroids drove infection deeper
  - Typically, 2-4 weeks with follow-up
  - If not improving, consider that there are now cases of tinea resistant to terbinafine.

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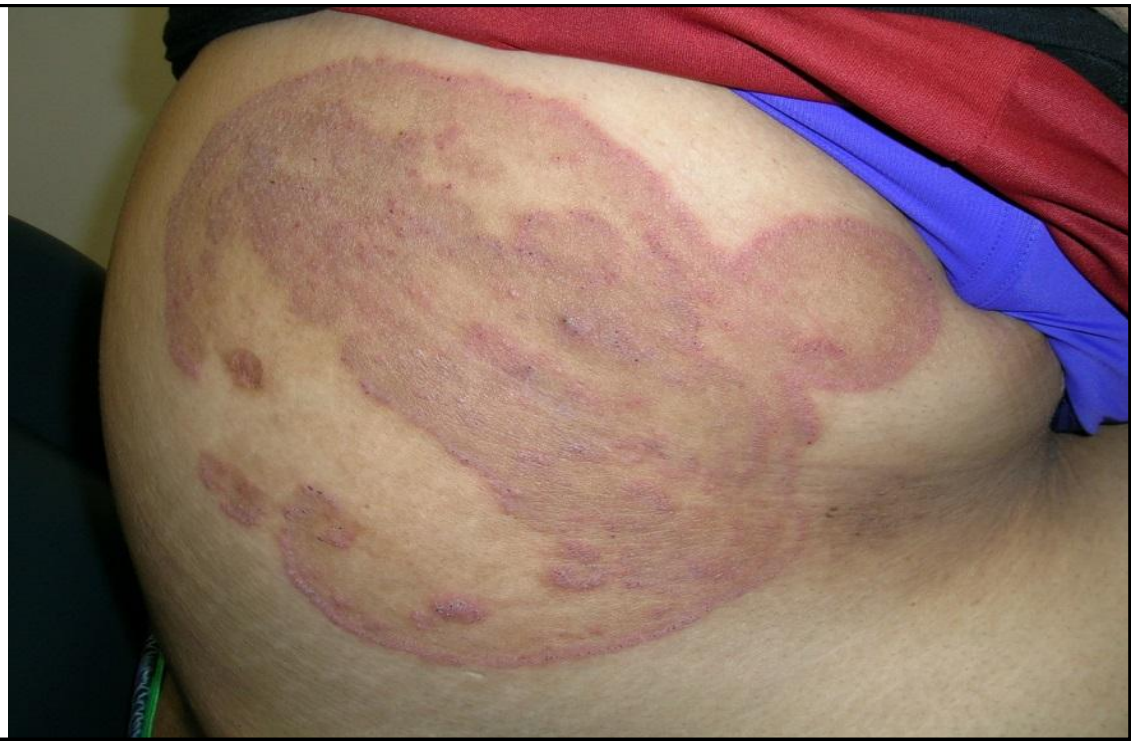

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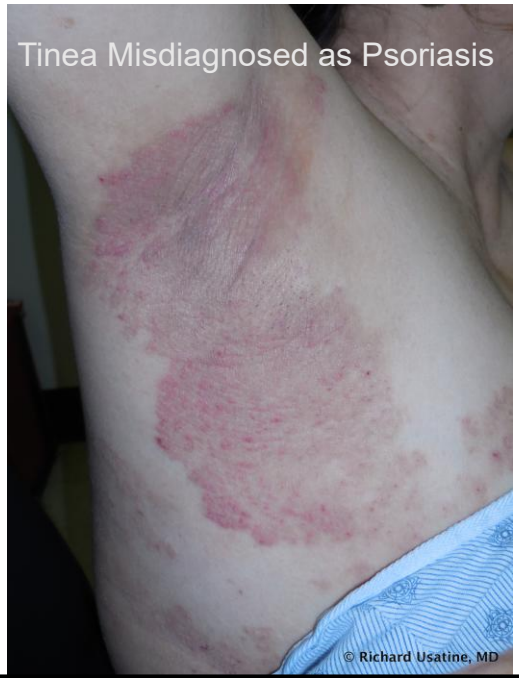
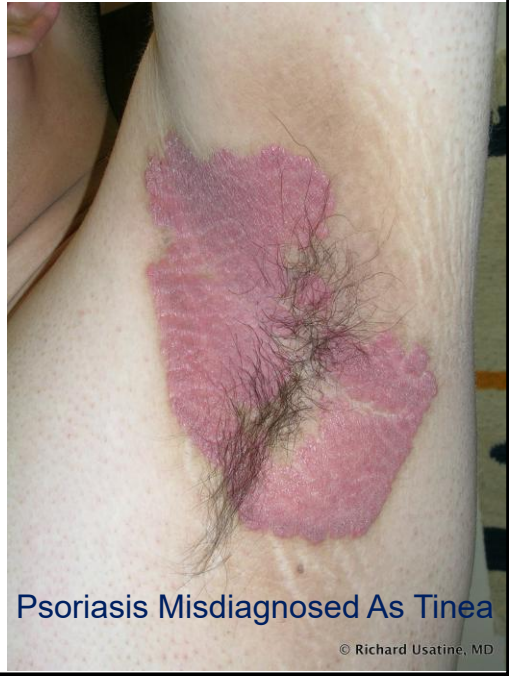
Tinea or Psoriasis?





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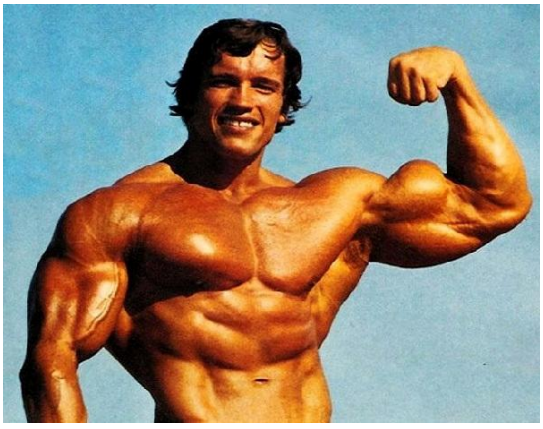
Steroids Are Very Useful

Especially topical ones in dermatology

- Atopic dermatitis
- Psoriasis
- Contact dermatitis
- Lichen simplex
- Lichen planus



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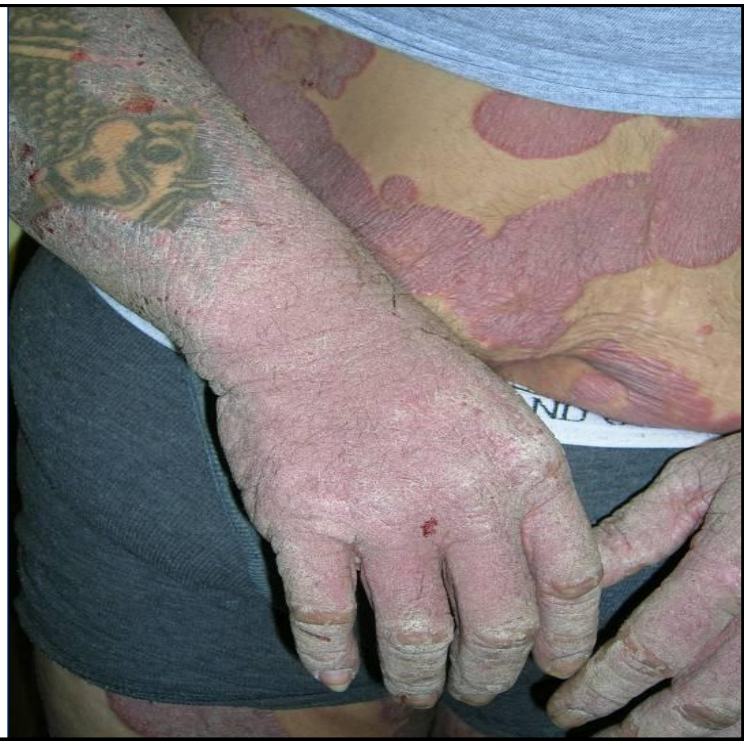
If the Patient Does Not Have a Preferred Vehicle, What Is the Best Vehicle to Use for This Patient?



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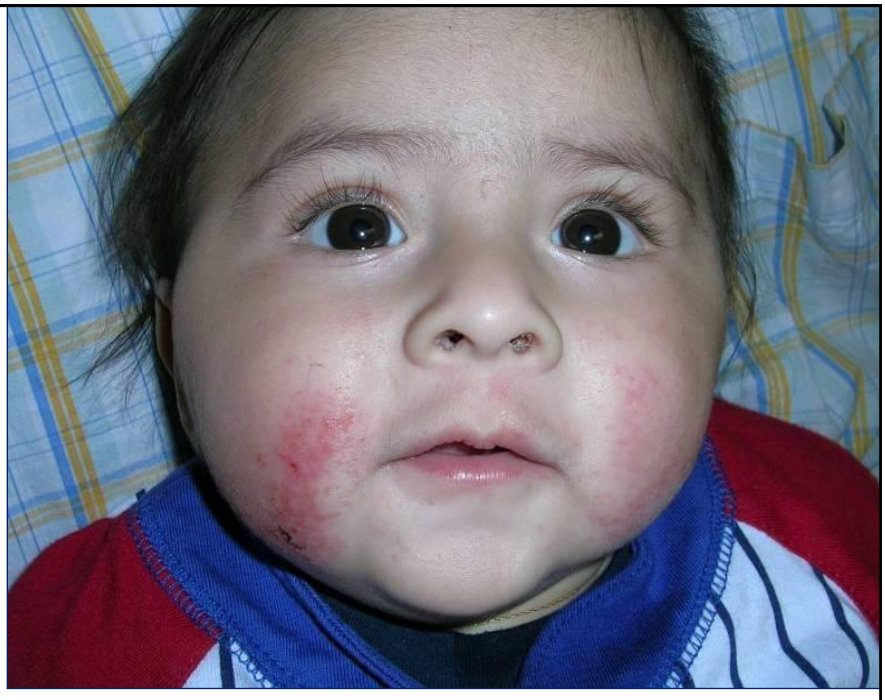
Which Topical Steroid Is Most Appropriate for This Child's Atopic Dermatitis?



51

Most Common Errors with Topical Steroids

- Not giving enough quantity for large areas and chronic conditions
- Not giving appropriate potency
- Using cream when ointment is better or visa versa

52

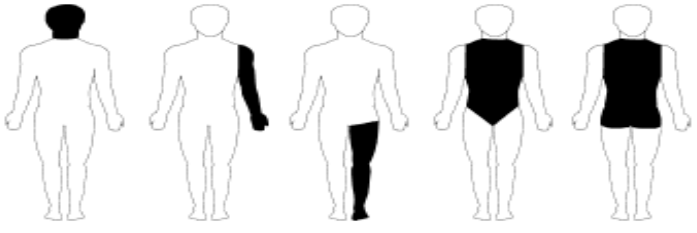
How Often to Apply

- Most topical steroids are approved for twice daily application and are prescribed that way.
- One systematic review revealed that using twice-daily applications of topical corticosteroids may be no more effective than once-daily application.

- Hoare C, et al. Systematic review of treatments for atopic eczema. Health Technol Assess. 2000;4(37):1-191.

53

ONE adult fingertip unit (FTU)*



Number of finger tip units (FTUs)

Age	Face & neck	Arm & hand	Leg & foot	Trunk (front)	Trunk (back) inc. buttocks
Adult	2½	4	8	7	7
Children:					
3-6 months	1	1	1½	1	1½
1-2 years	1½	1½	2	2	3
3-5 years	1½	2	3	3	3½
6-10 years	2	2½	4½	3½	5

* One adult fingertip unit (FTU) is the amount of ointment or cream expressed from a tube with a standard 5mm diameter nozzle, applied from the distal crease to the tip of the index finger.

Table 3. 'Finger tip units' (FTUs) of steroid preparation to apply to specific areas.[13,14]

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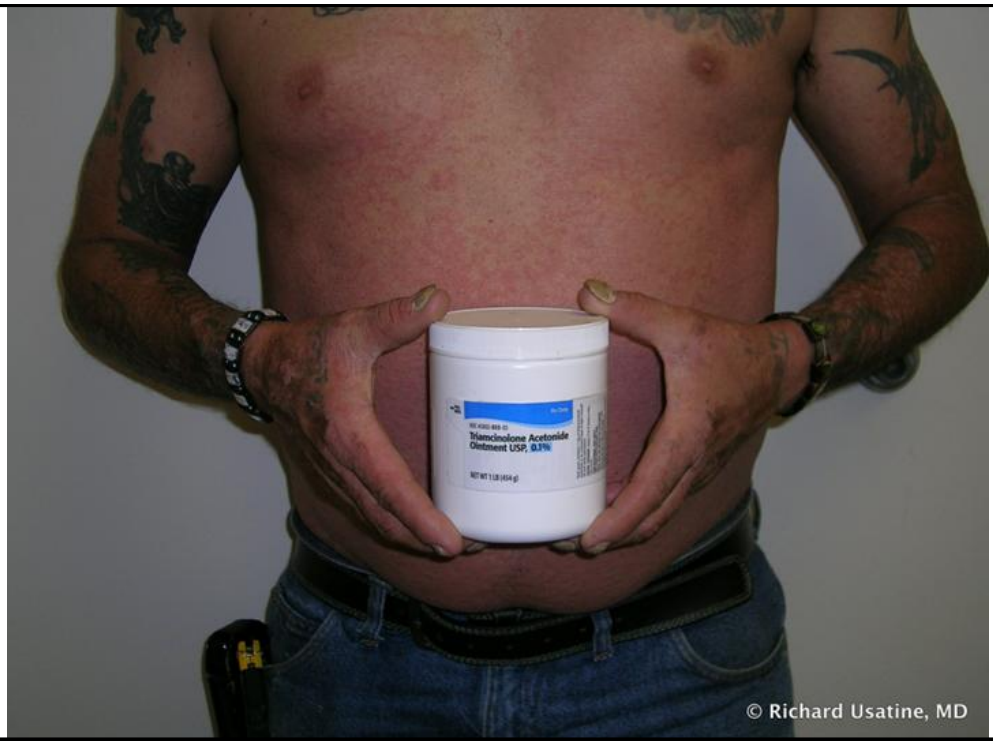
Large Amounts (Low Potency to High)

- Hydrocortisone – 30 gm tube and 454 gm tub (1 pound)
- Desonide – 60 gm
- Triamcinolone- 80 gm tube and 454 gm tub (1 pound)
- Fluocinonide:
  - 60 -120 gm cream or ointment
  - 60 -120 ml solution
- Clobetasol – 60 gm or 60 ml
  - Halobetasol – 50 gm
  - Betamethasone – 50 gm

55



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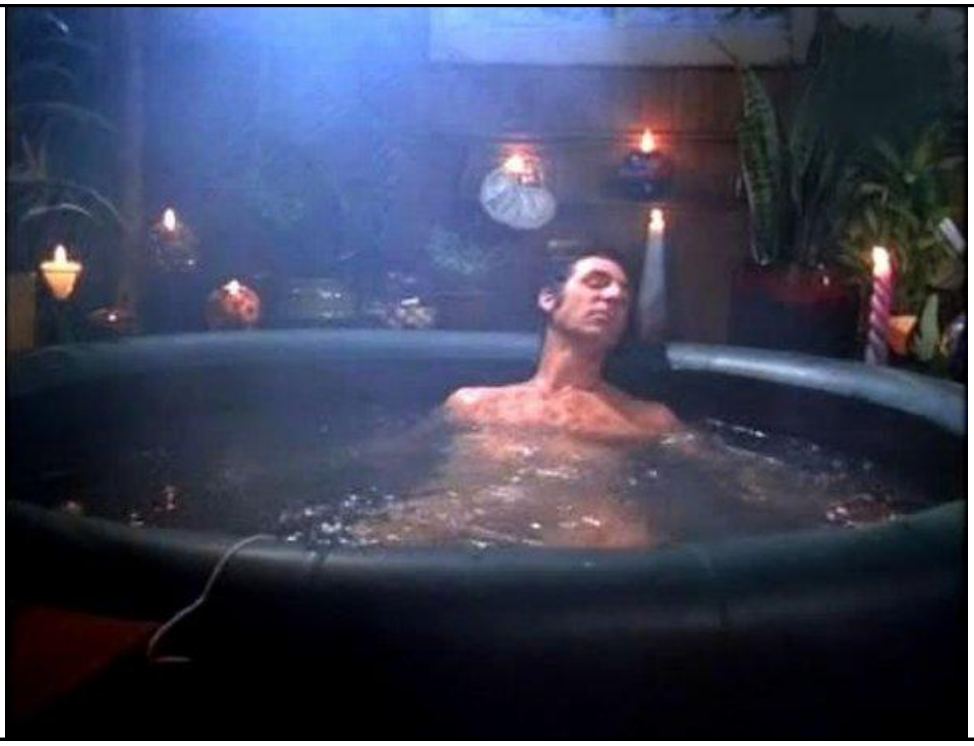

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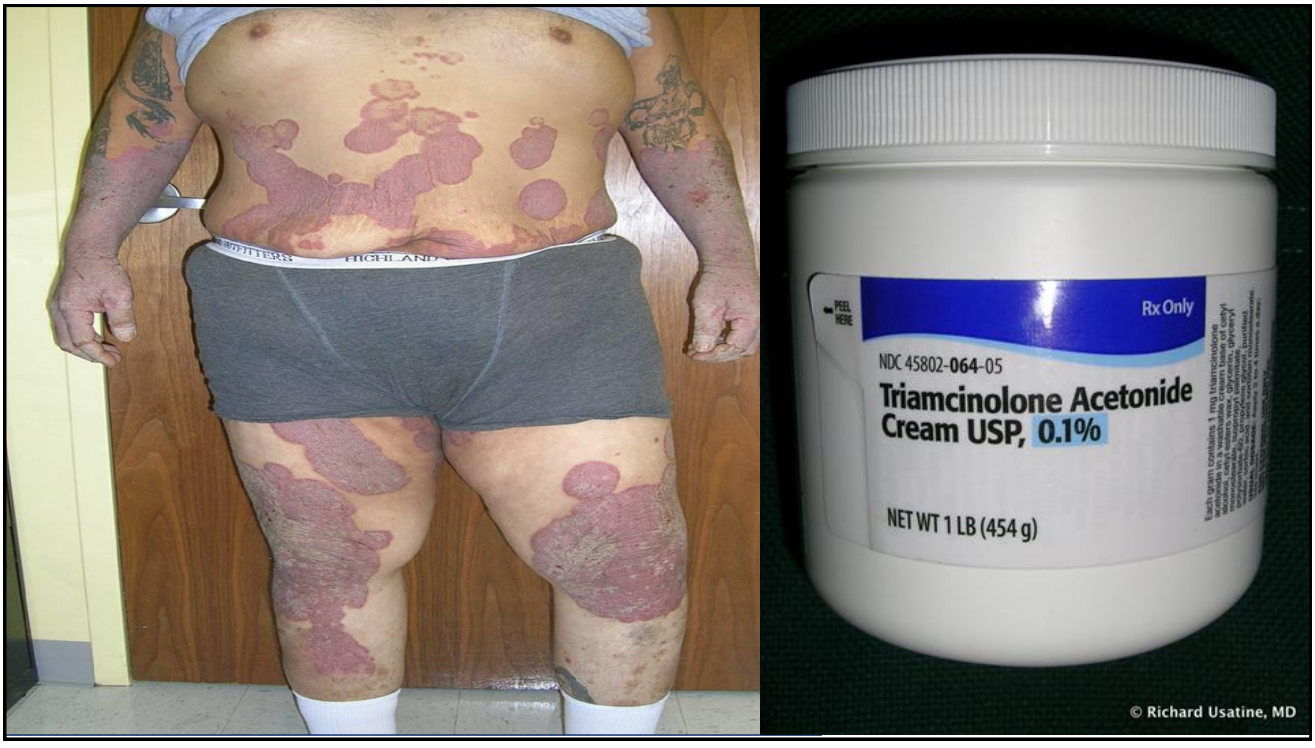
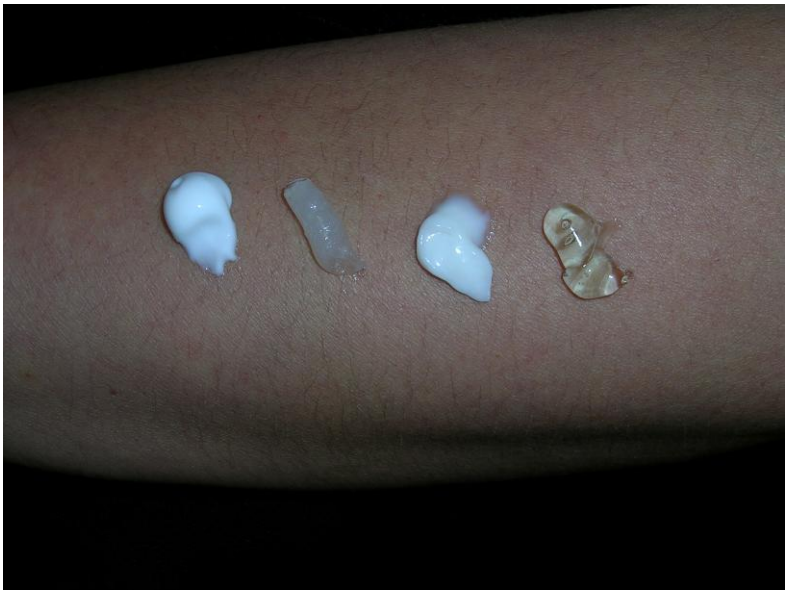

Rx Only
NDC 45802-064-05
Triamcinolone Acetonide
Cream USP, 0.1%
NET WT 1 LB (454 g)
© Richard Usatine, MD

58

Vehicles

Cream Ointment Lotion Gel



59

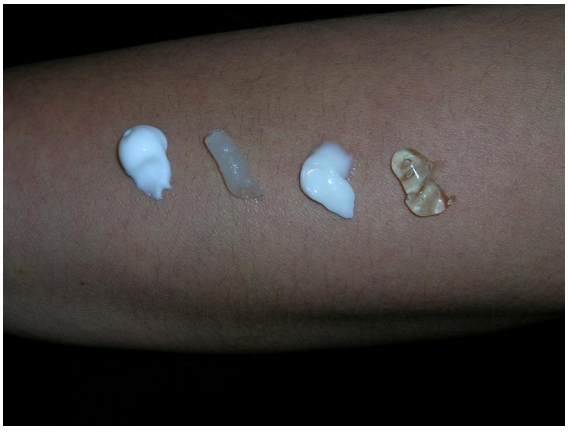
Vehicles

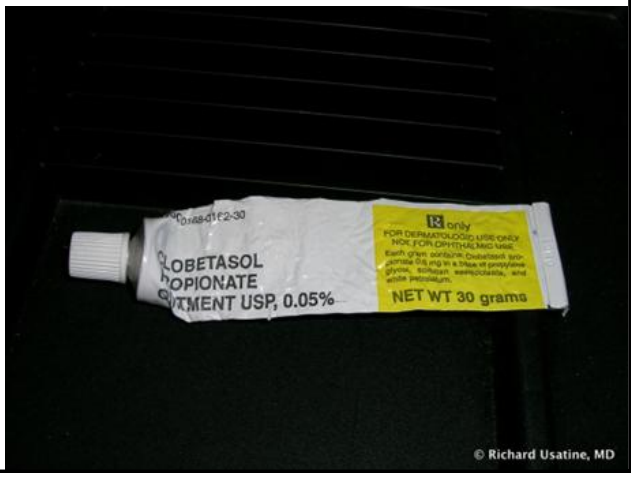
- Creams – easy to apply but may sting opened or cracked areas
- Ointments – best vehicle for lesions that are dry, scaling and cracking
- Lotions – easy to rub into areas with hair
- Gels – rub in easily without changing skin color
- Solutions – very easy to apply to the scalp
- Foams – newer vehicles with high patient acceptance and high penetration

60

Best Vehicle

- Is the vehicle that the patient will use
- Ask patient preference

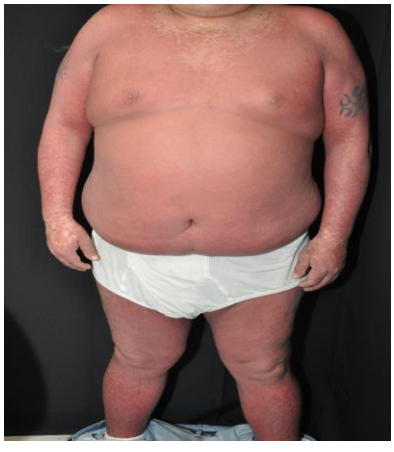




61

When Psoriasis Covers Over 80% of the Skin, the Best Initial Treatment From the Following Choices Is:

A. Oral prednisone with taper
B. IM triamcinolone 40 mg
C. Narrow band Ultraviolet B light
D. Topical triamcinolone ointment with wet wraps



CONTINUING EDUCATION COMPANY

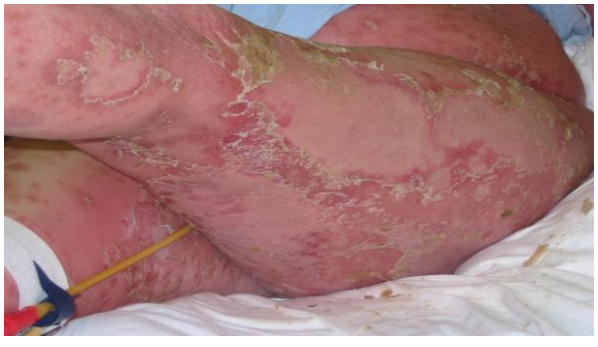
62

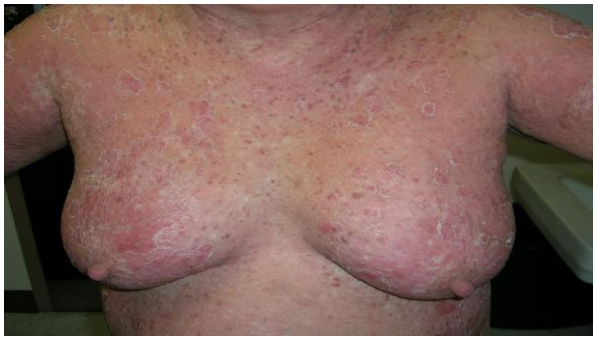
Do Not Use Oral Prednisone for Psoriasis

63

Oral Steroids

- Prednisone even when tapered can precipitate generalized pustular psoriasis and it doesn't even work very well





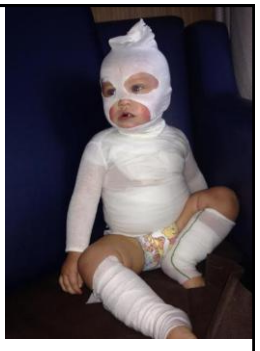
64

Extensive Psoriasis

- Large areas can be covered with the 1 pound tub
- Penetration can be increased with wet wraps
- Avoid prednisone for psoriasis
  - Potential danger
  - Not very effective

65

Wet Wrap Therapy

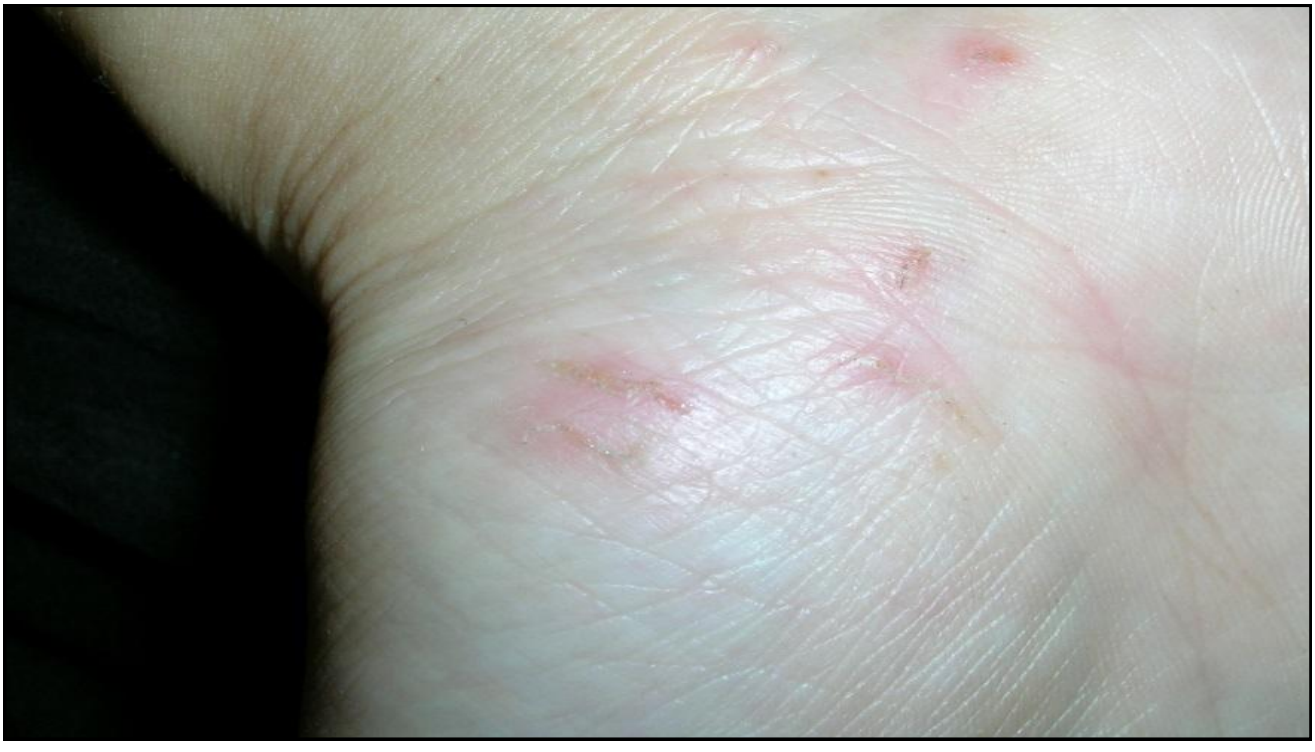


- Apply steroid ointment or cream to the inflamed skin (0.1% triamcinolone)
- Use pajamas or other cloth and soak in warm water.
- Wring out excess water.
- Put the "dry layer" such as a blanket over the "wet layer."
- Leave in place overnight or 3 hours during the day but stop if the patient becomes chilled
- Perform daily for up to 2 weeks but do not use as long-term therapy

66


14 yo Boy Sent for
Psychotherapy for His
Persistent Itching for
Over 9 Months

67



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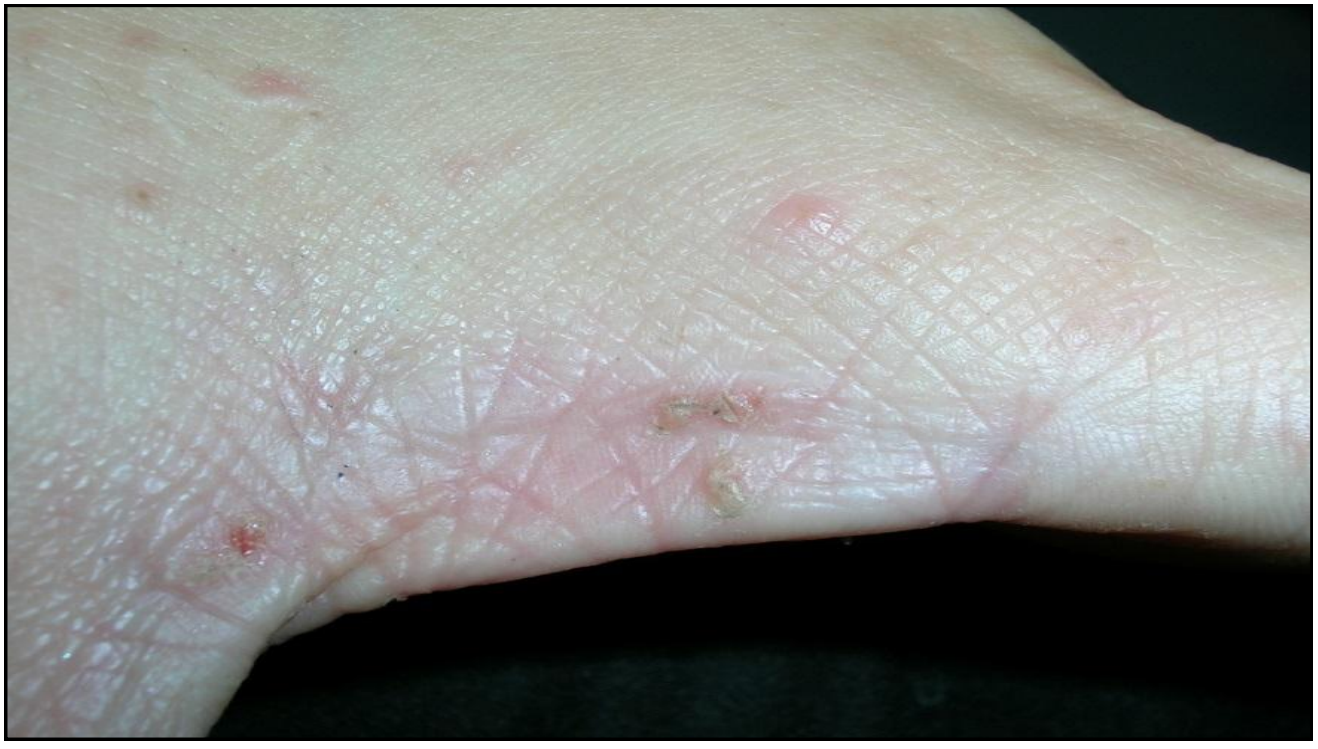

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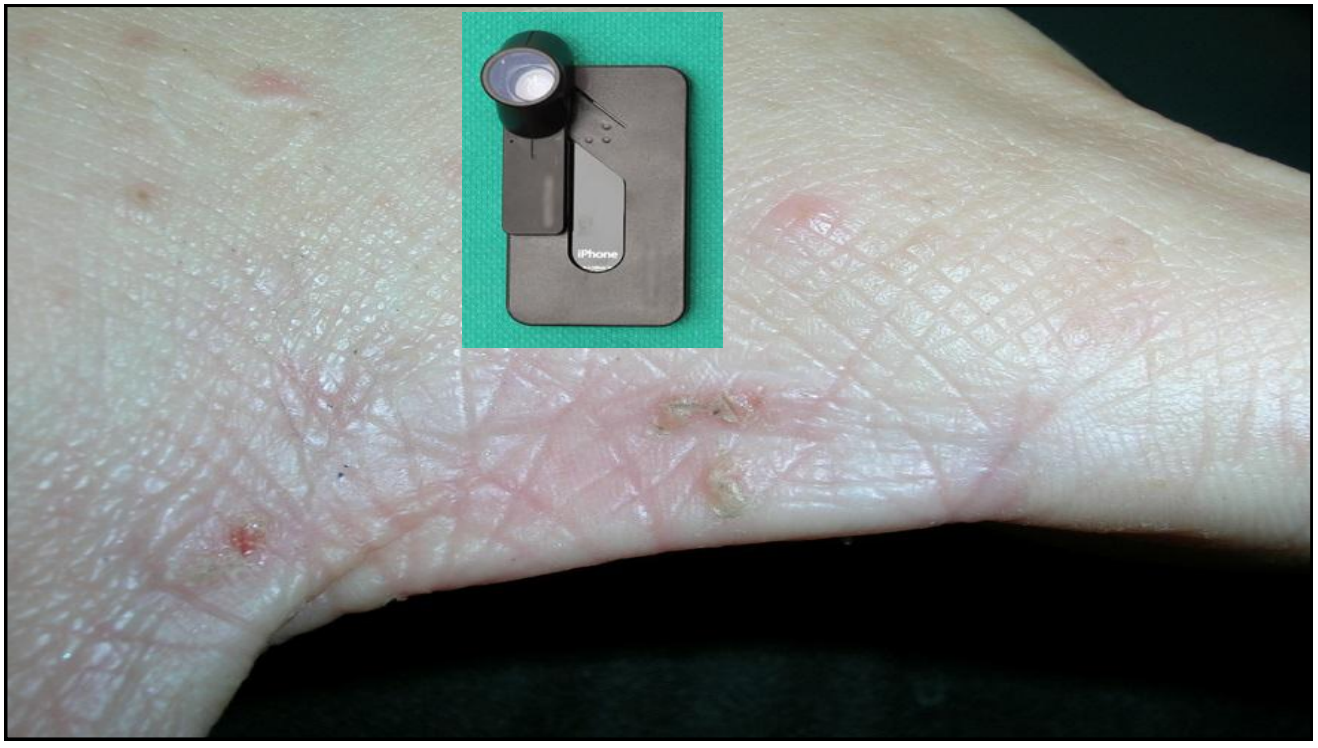

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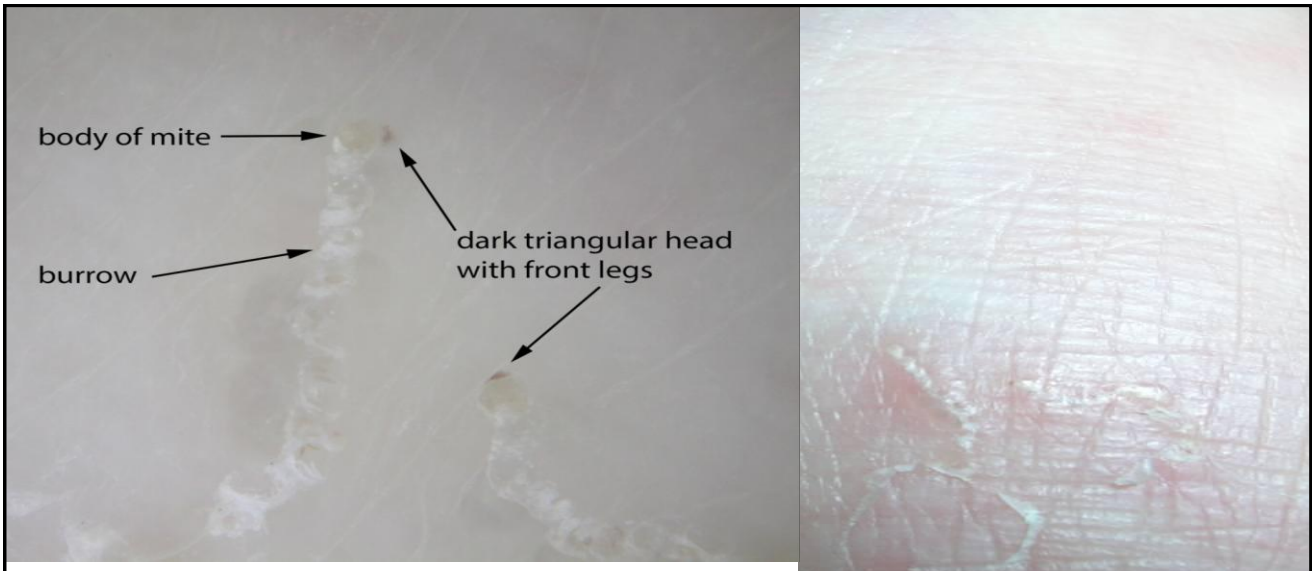

Dermoscopic Signs of Scabies:
Triangle on Top of Circle
Delta Wing Jet Plane with Contrail

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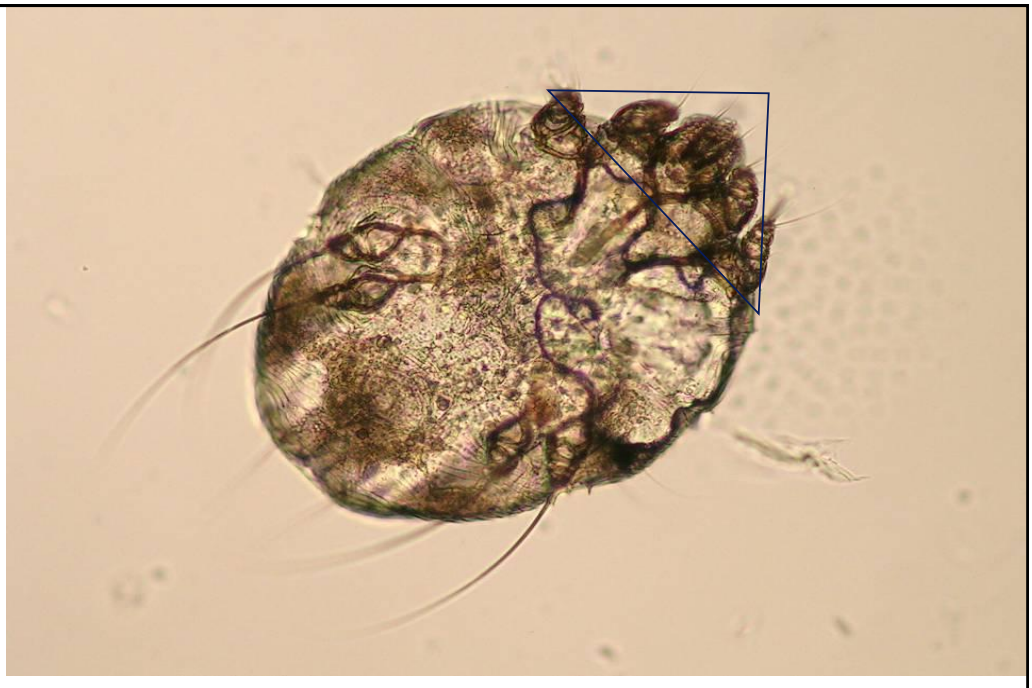
Scabies mite



72

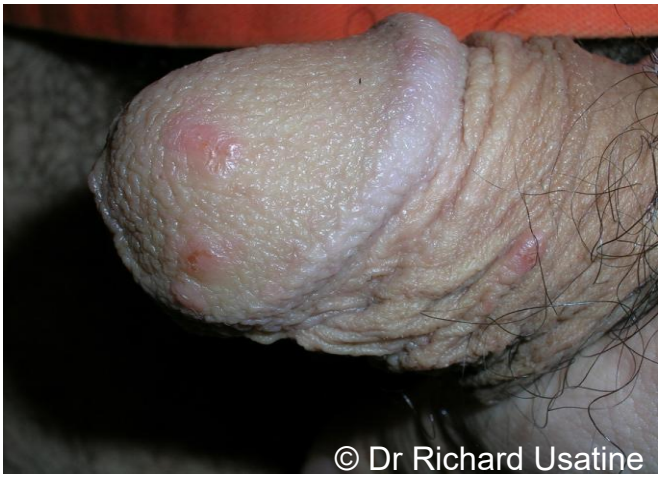
Scabies

- One of the most over diagnosed and missed conditions.
- Not every itchy rash is scabies.

73

Pruritic papules on the penis

- Are almost always caused by scabies mites
- Especially when the papules are on the glans
- The mites can be seen in these papules with dermoscopy
- This can be sexually transmitted but often is autoinoculation



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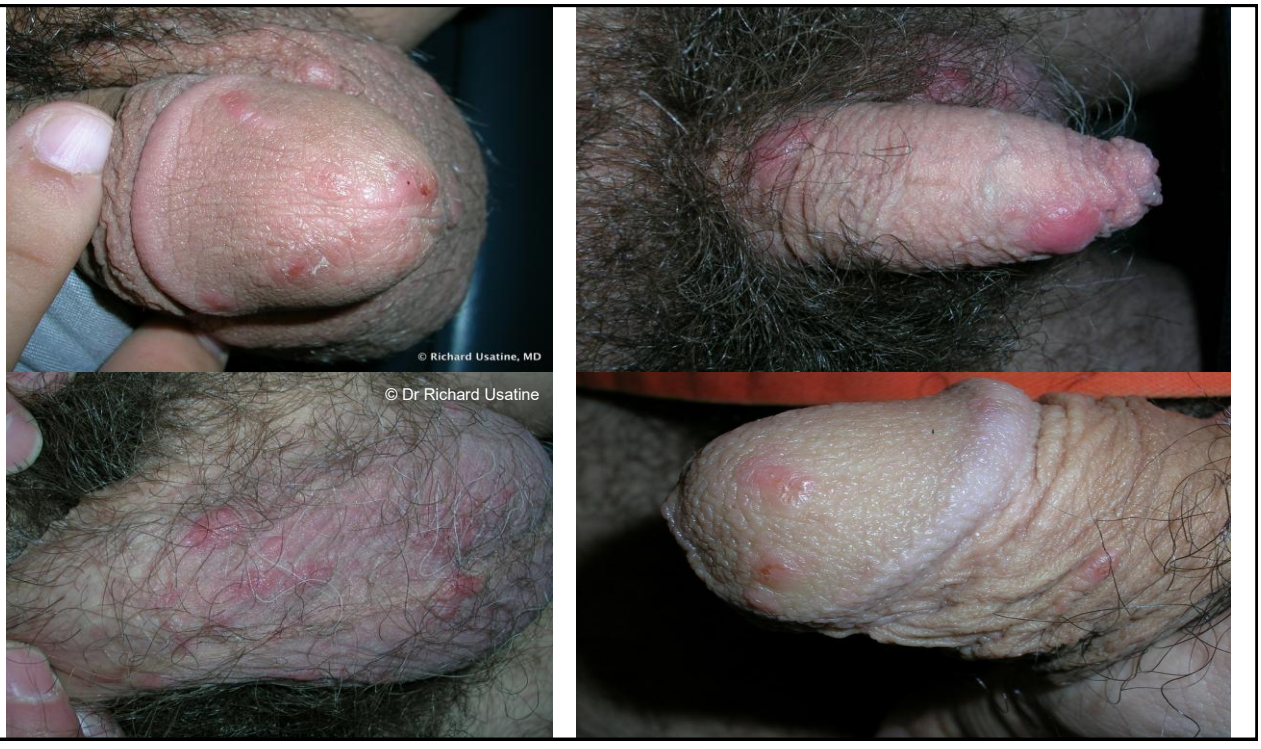
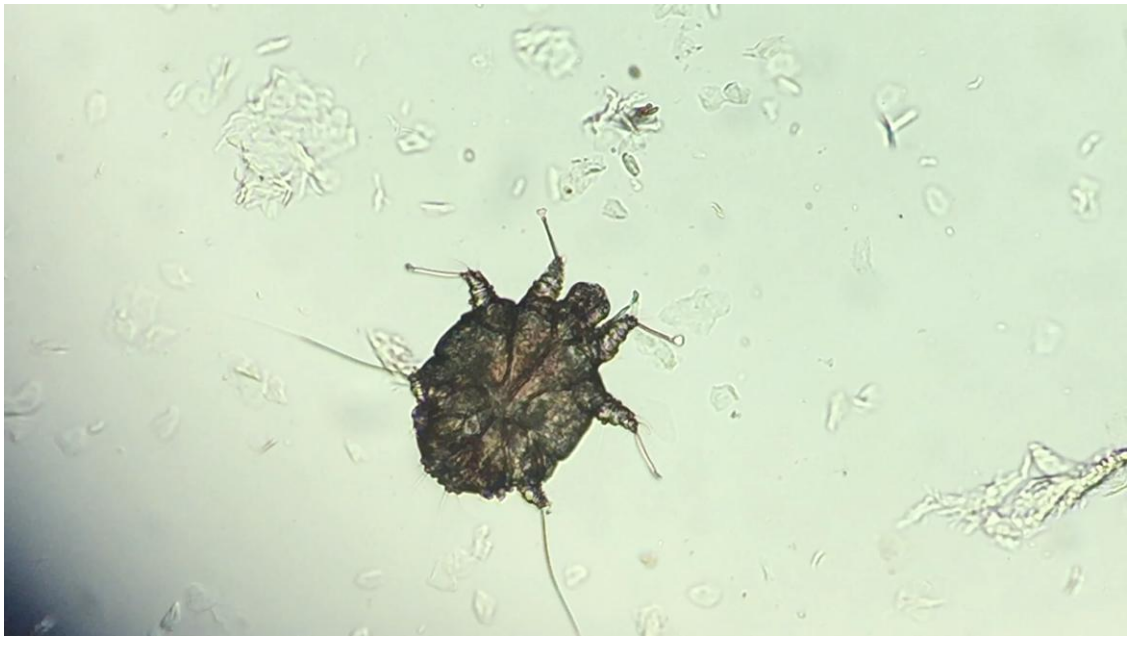


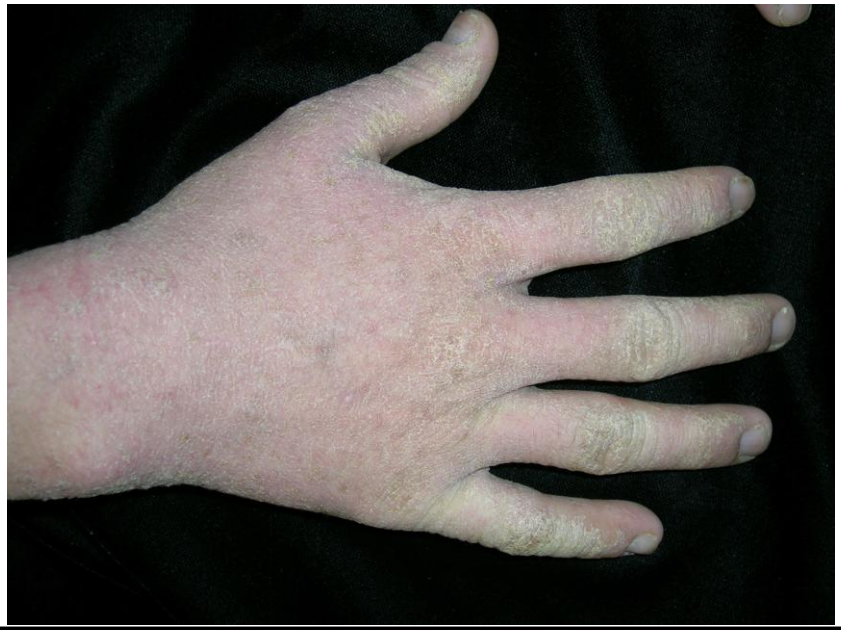
75

Saturday Night Fever



76

22yo Man with Itching and Scale on His Hands and Feet for 6 Months



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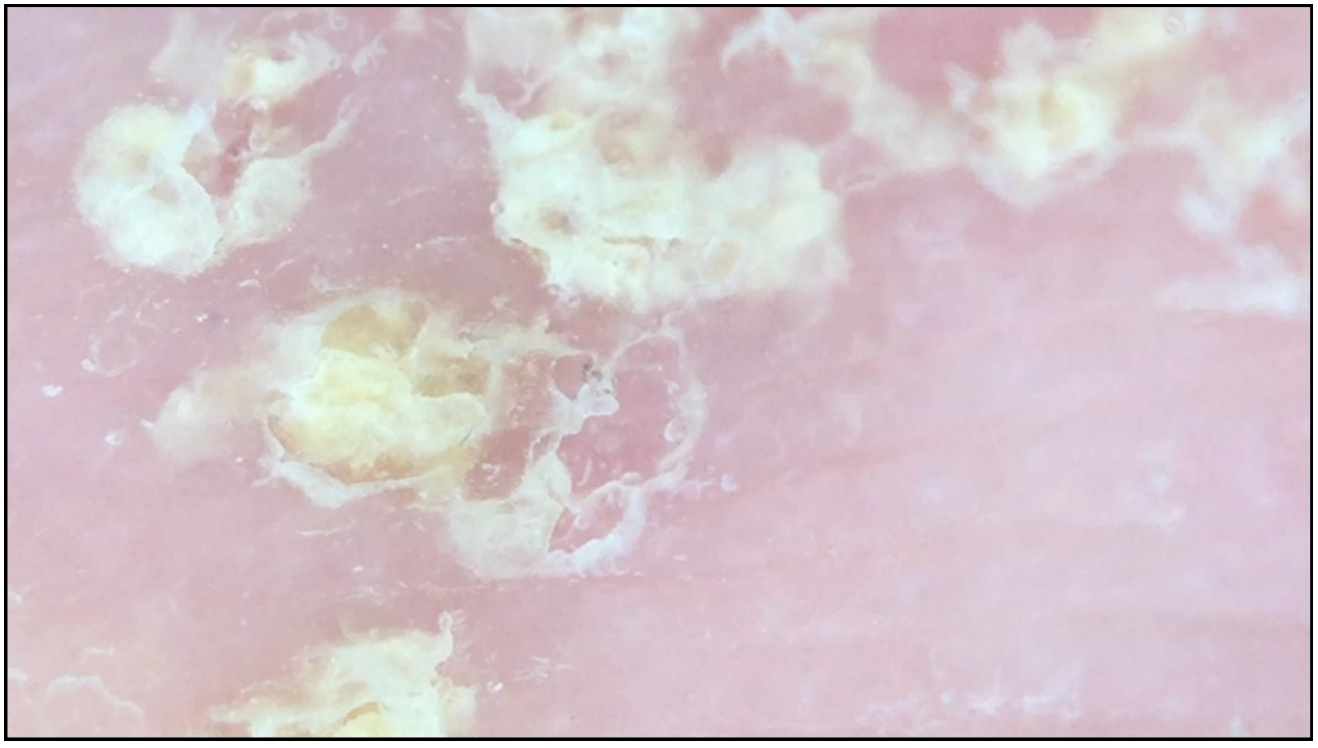

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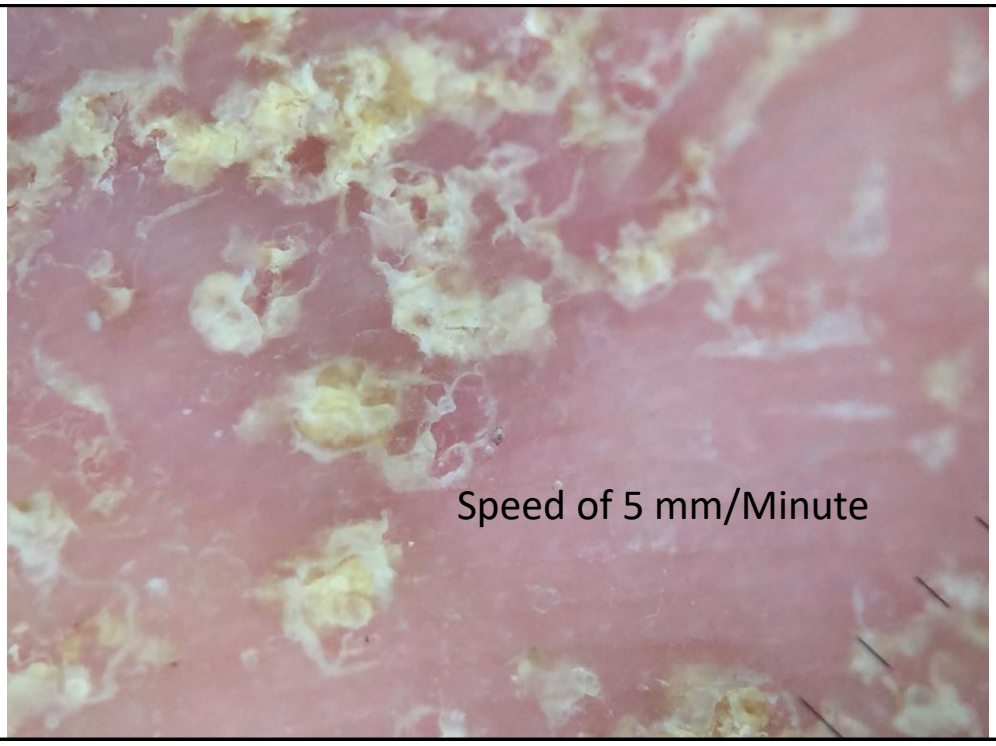
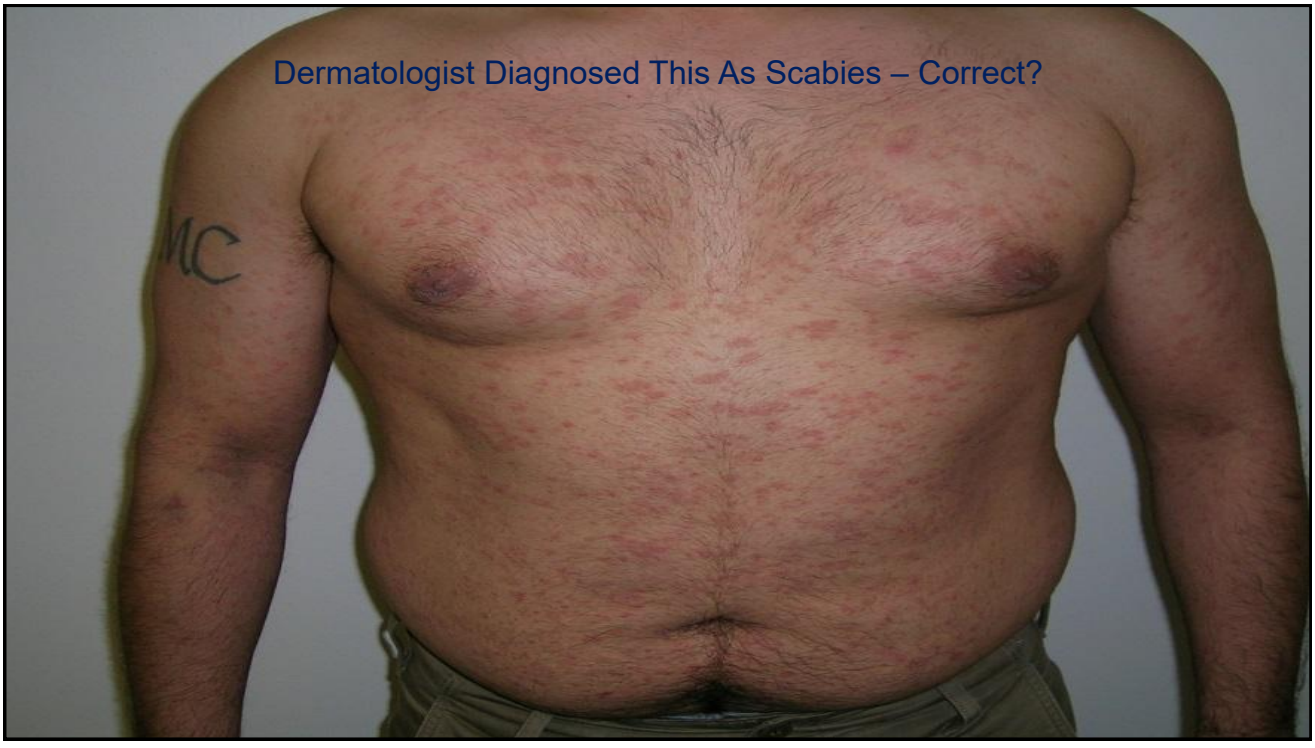
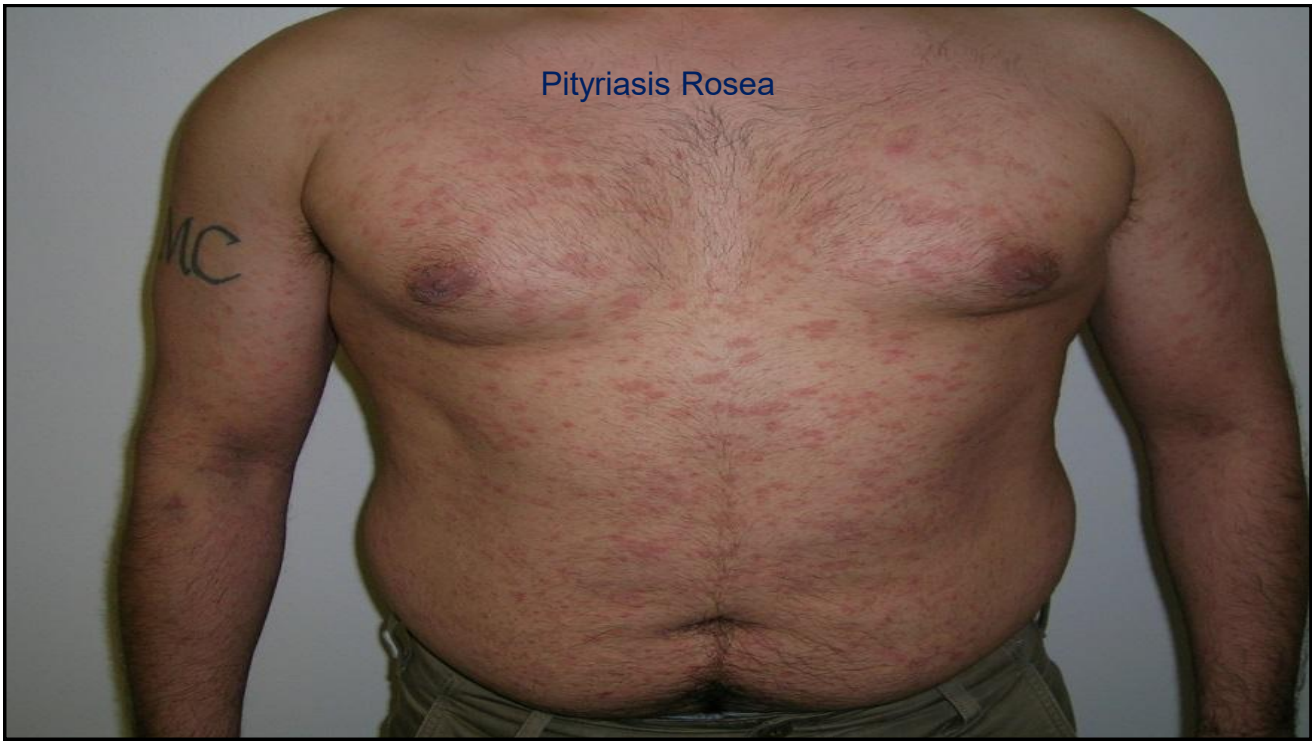

Speed of 5 mm/Minute

79


Dermatologist Diagnosed This As Scabies – Correct?
MC

80



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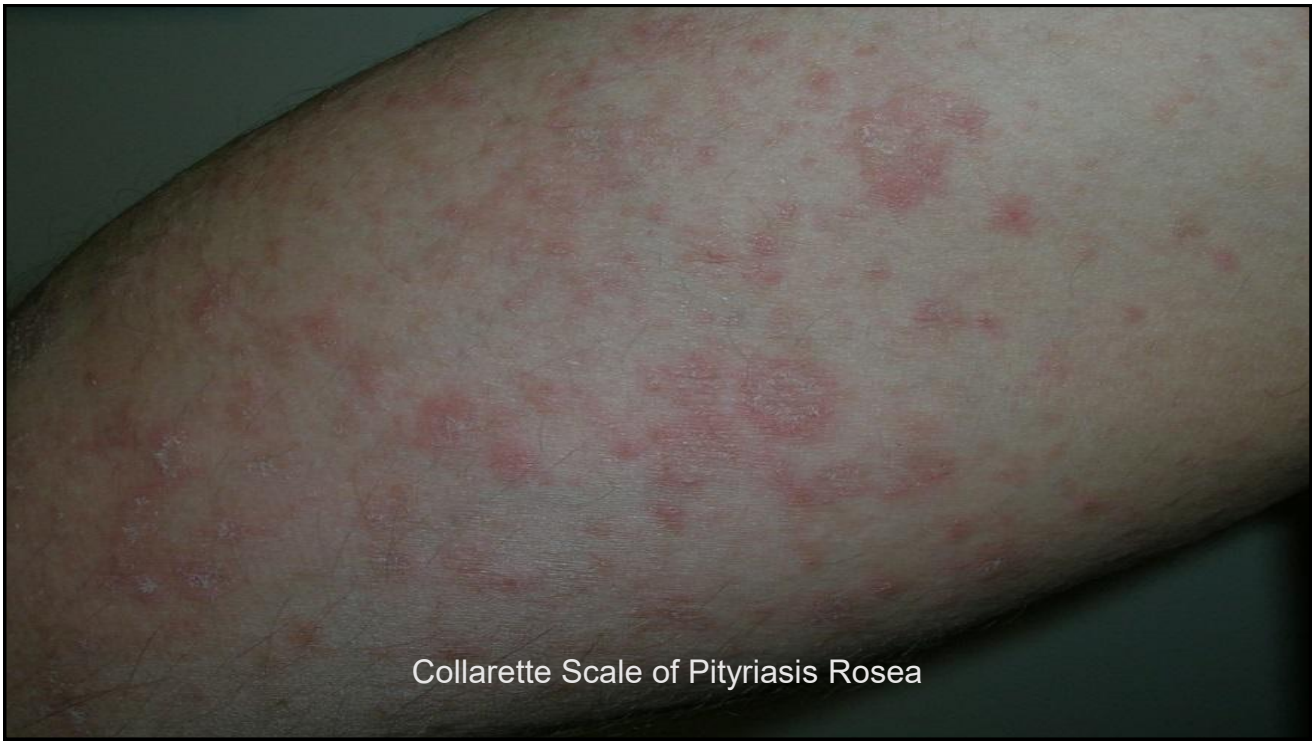
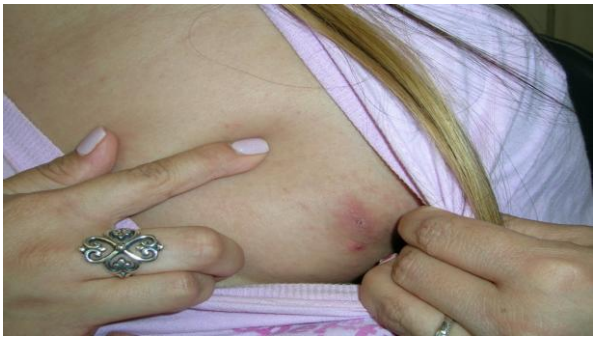
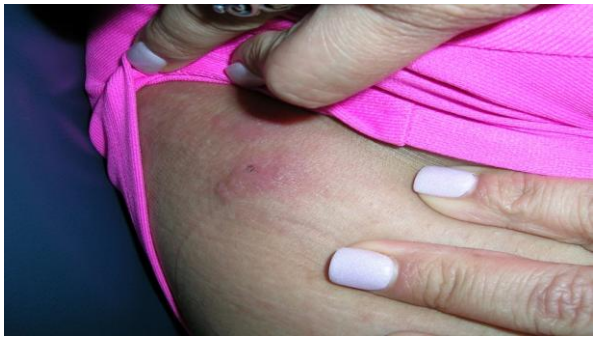


82

Young Woman with Itching Nodules in Axilla and Groin





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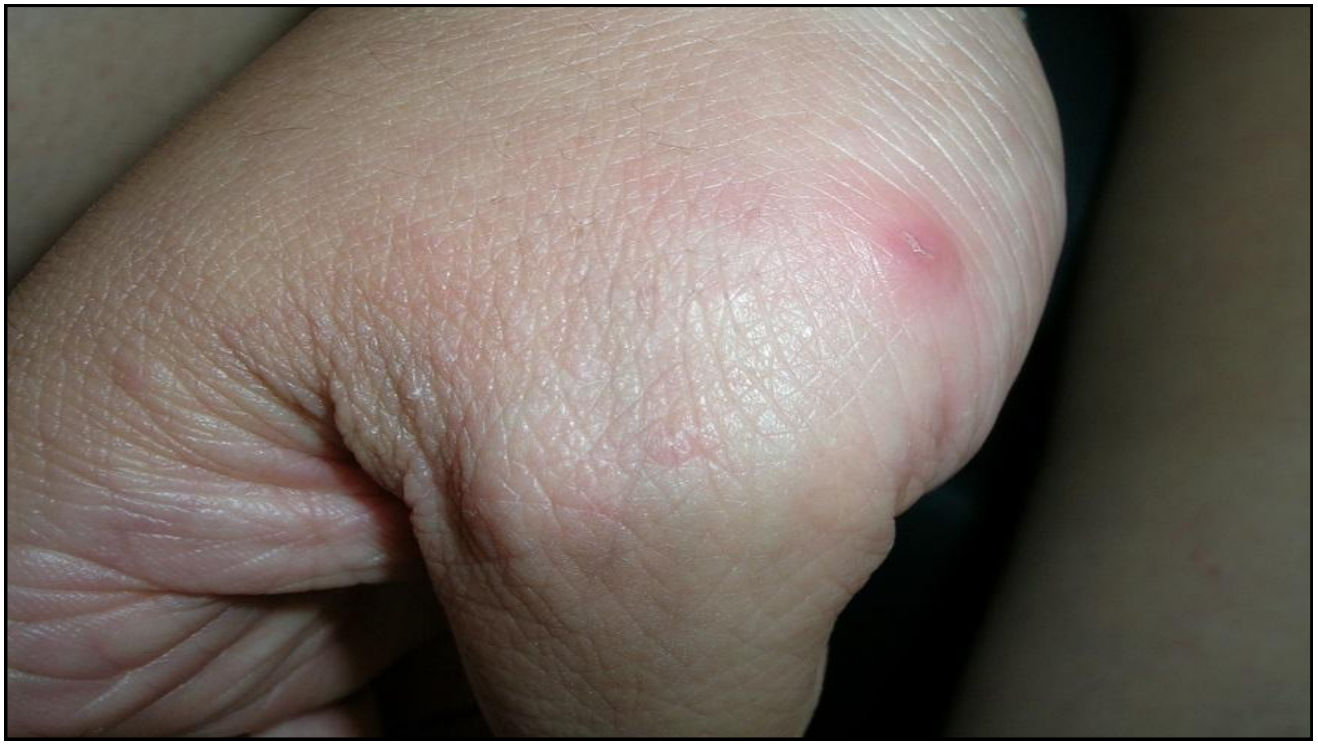

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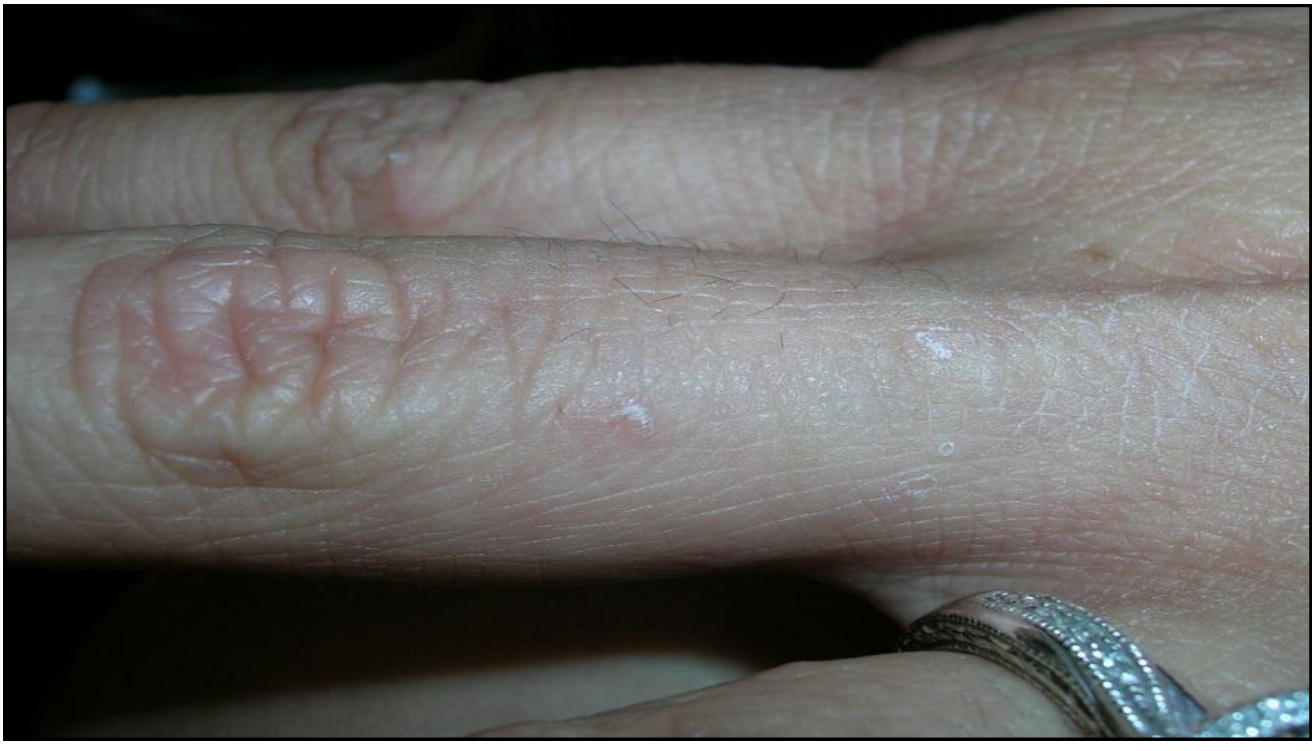
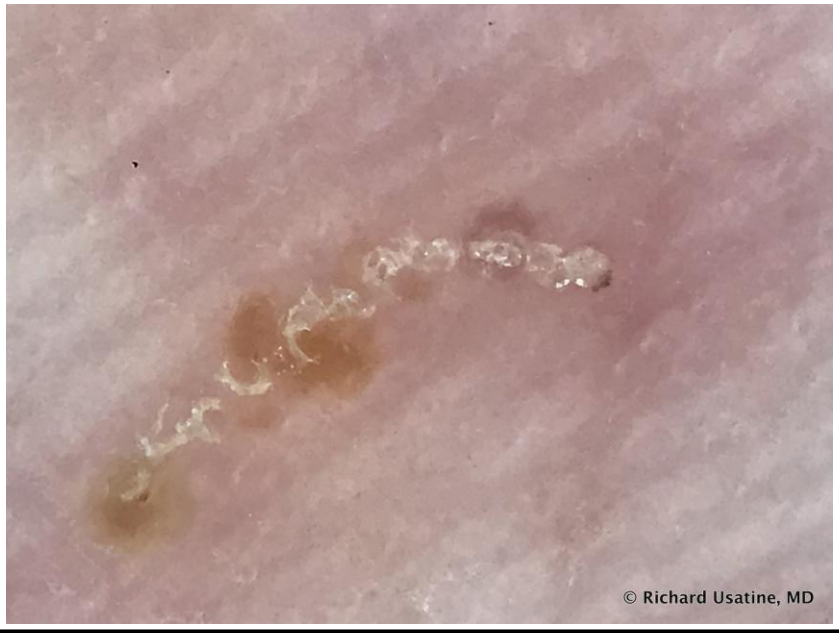


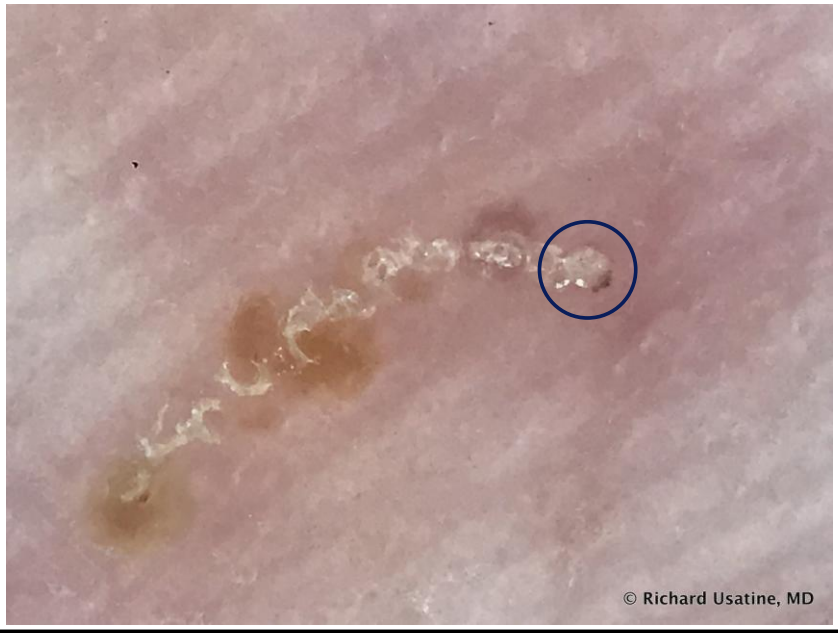
85

See the Mite and Burrow with the Dermatoscope



86

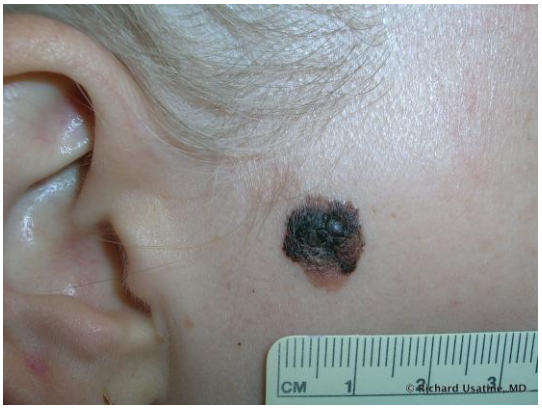
See the Mite and Burrow with the Dermatoscope

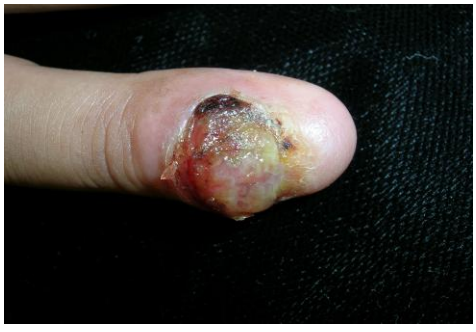


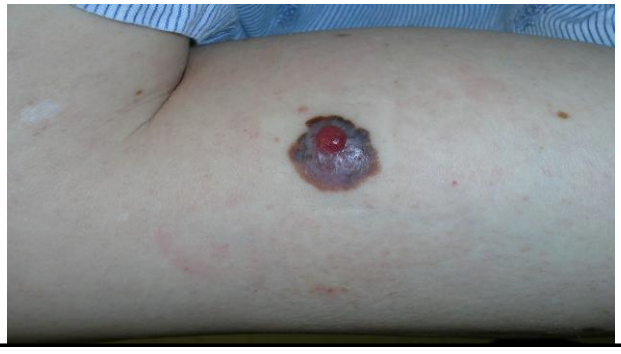
No More Guessing

87

Delayed Diagnosis of Melanomas





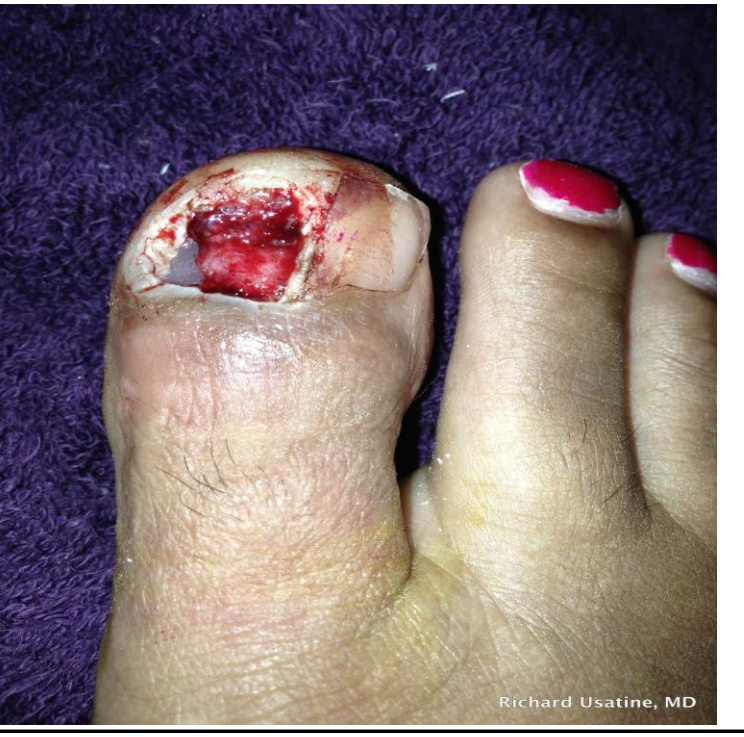


Biopsy Today, Soon, or Pick Up the Phone to Call Someone to Do the Biopsy ASAP

88

This Was Not Fungal or Bacterial.

This Young Woman Died from This Melanoma.



89

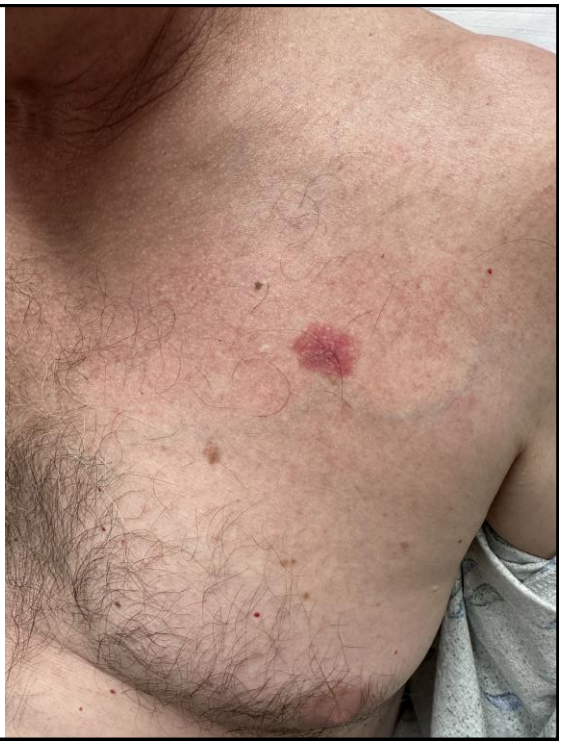
Missed Melanomas – Malpractice Cases

- Cryosurgery of an unknown pigmented lesion that was described as suspicious in chart.
  - If suspicious this needs bx
- Shave biopsy of a lesion thought to be a seborrheic keratosis and throwing it away (melanomas can look like an SK)
  - If you bx a lesion, please send it to pathology
- Ignoring patients' complaints that a pigmented lesion is itching, bleeding and newly tender (documenting this but not doing the biopsy)
  - These can be signs of melanoma, please do bx.

90

Missed sBCC

- Treated with antifungals
- Needed a biopsy



91

Common Mistakes

1. Misdiagnosing inverse and plantar psoriasis as a fungal infection
2. Misdiagnosing fungal infections as dermatitis or psoriasis and giving steroids
3. Giving oral steroids for psoriasis
4. Giving the wrong steroid vehicle by not asking the patient
5. Not giving enough topical steroids
6. Over diagnosing or missing scabies
7. Delayed diagnosis or missing the diagnosis of melanoma or other skin cancers.

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Avoiding Mistakes

1. Learn patterns of inverse and plantar psoriasis
2. Look at nails and other areas for clues to dx
3. Use KOH preparations/fungal cultures
4. Be careful when you prescribe steroids – topical and oral
5. Don’t give oral steroids for psoriasis
6. Ask patient preference for vehicle
7. Give enough topical steroids when needed
8. Consider getting a dermatoscope to diagnose scabies and skin cancer with greater accuracy
9. Biopsy or refer any lesion suspicious for melanoma or skin cancer

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